California MEDICINE

APRIL 1953

OFFICIAL JOURNAL
OF THE CALIFORNIA MEDICAL ASSOCIATION

UME 78 NUMBER 4

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Volume 78 • APRIL 1953 • Number 4

Coccidioidomycosis as a Tool in the Study of Granulomatous Disease

J. WALTER WILSON, M.D., Los Angeles

• In spite of a far-reaching research effort extending over many years the processes by which the human body acquires immunologic resistance to most of the chronic infectious diseases remain obscure. With few exceptions, methods by which such resistance may be artificially produced or stimulated have not been discovered. In coccidioidomycosis there are several instances in which the immunologic reactions seem to be less complicated than those encountered in tuberculosis, for example. More concentrated research in coccidioidomycosis might lead to a better understanding of immunologic processes in general.

TO ONE STUDYING the various disorders within that large group called "granulomatous diseases," striking similarities in pattern are evident. Sometimes the similarities seem to transcend the differences. With better understanding, some of the dissimilarities are explainable and closer adherence to a general pattern is emphasized. Perhaps some of the hitherto elusive answers to questions regarding immunologic processes—in tuberculosis, for example—might be obtained by studying coccidioidomycosis which, while similar in many ways to other granulomatous diseases, is more suitable for research.

For 43 years after the first case was reported in 1892, coccidioidomycosis was considered to be a very rare, chronic, wasting disease, originally pulmonary but soon becoming disseminated extensively throughout the body, and fatal in about 50 per cent of cases. In 1935, however, Gifford and Dickson presented revolutionary evidence which led to recognition that in certain endemic regions, notably the San Joaquin Valley of California, infection occurs in almost all persons within the first four years of residence in such a region, owing to inhalation of dust containing the fungus in the form of arthrospores.

It was learned that at least 60 per cent of the persons infected were entirely unaware of the infection throughout whatever "active" phase it had in them, yet they acquired thereby a complete and permanent specific immunity. Persons who had clinical symptoms also acquired perfect immunity, but only after an illness varying from the most trifling respiratory inflammation to pulmonary symptoms and signs so severe that, were they caused by any other infective agent, would certainly be expected to cause death. In only one case in several thousands in which so-called "primary infection" occurs does complete immunity fail to develop; and in that event the disease progresses to the disseminated, granulomatous, often fatal form in which it was first known.

Several early investigators developed and attempted to use for diagnostic purposes an extract of cultures of *Coccidioides* (hereafter called "coccidioidin"). It was injected intracutaneously in the

Chairman's Address: Presented before the Section on Dermatology and Syphilology at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

manner of Koch's old tuberculin. The results were confusing and the test was considered to have little specificity: it yielded highly positive reactions of the delayed "tuberculin" type in many persons who were obviously healthy, and on the other hand tended toward negativity in persons who could easily be proved to have the disease in the most serious form.

After Gifford's and Dickson's observations, however, the reasons for these surprising phenomena became clear. A highly positive reaction to the test develops during the acquisition of specific immunity and persists for many years. It was apparent that the former "false positives" occurred in persons who either were then acquiring specific immunity or had been infected and had recovered with permanent immunity and persistent ability to respond to the test. The "false negatives" occurred in cases in which the disease was progressing unhindered by any perceptible degree of specific immunity.

ALLERGIC MANIFESTATIONS IN THE SKIN

It was also observed that in many patients allergic manifestations in the skin, such as erythema nodosum and erythema multiforme, occurred in the early phase of coccidioidomycosis. Such patients rarely die of the disease and the syndrome soon became useful to clinicians as an indication of favorable prognosis. When tested intracutaneously with coccidioidin, the skin of all such patients reacts violently, necessitating the dilution of the material to 1:10,000 if undue discomfort and necrosis are to be avoided. To emphasize further the close correlation between coccidioidin and the immunologic or allergenic material responsible for the cutaneous manifestations, it was occasionally observed that erythema nodosum was actually precipitated or caused to recur by the application of the test material.

Thus originated the concept that the degree of immunologic resistance which the patient was mobilizing against the disease could be quantitatively measured by the delayed tuberculin-type reaction produced by the intracutaneous injection of various dilutions of coccidioidin. This theory still serves clinicians admirably, although it is not valid to infer either that the immunity depends upon such sensitivity or that it invariably parallels it.

Some persons, however, do die of the disseminated infection even though they have a fair degree of reaction to the intracutaneous test. It seems likely that in such cases the disease swiftly becomes so extensive as to overwhelm an otherwise satisfactory degree of developing immunity. Thus an accurate prognosis cannot be given after merely measuring the fighting power which the patient is mobilizing against the disease; it is also necessary to measure the fighting power of the adversary, which is the extent and severity of the infection. For this vital information clinicians have learned to rely upon the reaction to another test in which coccidioidin is used as the antigen in the fixation of complement, carried out exactly as in the quantitative Kolmer modification of the Wassermann test. It may be necessary to dilute the serum serially to eight or ten tubes (1:128 to 1:512) to determine the endpoint. In the case of mild infections there is complete complement fixation only in the first few tubes, while the severest ones yield positive results throughout the series. Fixation in a dilution of more than 1:32 (sixth tube) is likely to indicate dissemination. In experienced hands this quantitative test may be said to measure reliably the extent and degree of severity of the infection.

Through observation of the relationship of results of the skin test with those of the complement fixation test, prognosis can be determined with greater accuracy and at a much earlier time than by any other combination of clinical signs or laboratory procedures. A high degree of sensitivity to the intracutaneous test coupled with a negative or low-titred reaction to the complement fixation test indicates an excellent prognosis, even though all other evidence is to the contrary. (One exception must be pointed out: Meningitis can supervene and cause the death of the patient too rapidly for the tests to reveal the change in prognosis.) On the other hand a negative or low degree of response to the intracutaneous test accompanied by complement fixation in high dilution (over 1:32) means actual or impending dissemination and a serious outlook.

Naturally it is possible during the course of the disease for the reaction to either test to become more positive while reaction to the other declines, necessitating a change in appraisal of prognosis. For this reason several successive observations must be made to determine the trend of the sensitivities before ultimate accuracy may be achieved. This phenomenon of reversal in the reactions to the tests is observed, for example, when a patient with disseminated coccidioidomycosis completely recovers. Frequest testing will make it possible to anticipate the clinical improvement some weeks before it actually occurs.

There is an interesting variation in the time factors in these two reactions. After the incubation period of 8 to 28 days (more often 10 to 16) the reaction to the intracutaneous test usually becomes positive in from one to three weeks if it is to do so at all. The degree of reaction then rapidly increases, becoming highest in persons in whom there are other signs of allergic hypersensitivity such as erythema nodosum or erythema multiforme. Although it may decline somewhat, it remains high during

convalescence and continues so for many years. A slow decrease in degree of reaction over a decade or more is frequently observed. Thus, it is clear that a positive reaction to the intracutaneous test does not necessarily indicate the presence of active infection. It does, however, mean that the patient either has or has had the disease. The test is highly specific except when it is necessary to use undiluted or only slightly diluted coccidioidin to elicit a positive response; most of the non-specific cross reactions, such as that to histoplasmosis, occur when strong concentrations are used.

The complement fixation reaction appears more slowly, sometimes not until three months after the onset of the clinical symptoms. It rises to whatever height the severity and extent of involvement of the body may carry it and declines only as recovery progresses. It must become entirely negative before cure can be presumed. The specificity of this reaction is as high as that of the intracutaneous test; it may be stated that when the reaction is positive, in more than very small titre, the presence of active coccidioidomycosis is indicated.

In the early months of the infection the complement fixation reaction cannot be relied upon as an accurate measure of severity because of the delay in its appearance. Fortunately still another test employing coccidioidin serves to fill this gap, at least partially. When it is used as the antigen in a precipitin test with various dilutions of serum from the patient, a positive reaction indicative of active disease may be obtained as early as one week after clinical symptoms appear, and almost always by the end of the third week. This test, however, unlike the complement fixation test, elicits no reaction after three or four months regardless of the state of progress of the disease. It is thus of more value in establishing the diagnosis than in prognosis.

The fact that coccidioidomycosis is unique among diseases in that there is such a battery of immunologic tests so highly specific in providing accurate diagnostic and prognostic information is one of the features which make it so attractive for study.

Heretofore the antigen has been referred to simply as "coccidioidin," which implies that the same antigen could serve equally well in all three tests. It is true that all coccidioidin is produced in the same manner by culturing the organism in a synthetic liquid medium containing inorganic salts, glucose, glycerin, and only a single organic constituent related in any way to protein, the amino acid amide, asparagine. This protein-free medium is identical with that used for the commercial preparation of old tuberculin. The filtrate of such cultures contains the antigen. Owing to factors not yet explained or controllable, if several flasks are inoculated with *Coccidioides* in the same manner and cultured under identical circumstances, there will be considerable quantitative variation in the yield of coccidioidin and a very surprising qualitative variation as well. One flask may yield a high concentration of coccidioidin which will be found admirably suited to all three tests while another may supply none of the complement fixation factor while producing both skin testing and precipitation testing antigens very efficiently. The power to react in the complement fixation test can be removed from coccidioidin by heating or by any of several chemical treatments, while its skin testing efficiency remains unimpaired even by autoclaving. During these processes a small percentage of nitrogenous material, non-protein in nature, is destroyed and with that destruction the capacity to fix complement vanishes. Further chemical attacks upon the molecule are known which can remove its capacity to evoke the skin test reaction while it still retains its activity for precipitin reactions. Coccidioidin is thus probably a complex polysaccharide molecule containing several haptene groups, some of which may be amino acids.

It is interesting to examine more fully the subject of hypersensitivity as evidenced by the reaction to the intracutaneous injection of specific material. Identical responses of tuberculin type have been observed to occur following contact of bodily tissues with many different kinds of noxious materials such as bacteria, fungi, viruses, rickettsiae, animal parasites, protozoa, foods and danders. It seems unlikely that nature would furnish such a mode of reaction so universally if it had no beneficial effect, and yet in most instances hypersensitivity appears to be harmful. This particular type of hypersensitivity has been best investigated as it occurs in the tuberculin test, and it was long regarded as an essential factor in acquired immunity to tuberculosis. In recent years, however, convincing evidence has been assembled that there is no relation between the two. It is pointed out that in tuberculosis the degree of hypersensitivity does not parallel the degree of acquired immunity; that the inflammation resulting from hypersensitivity does not prevent the spread of the bacilli which the inflammation of immunized tissue achieves; that effective resistance can be established without simultaneously establishing hypersensitivity; that acquired immunity can be passively transferred while hypersensitivity cannot; and finally that acquired resistance persists after hypersensitivity has waned or has been abolished by desensitization. Similar evidence has been assembled in a number of other diseases; so much in fact that it seems like heresy to maintain that in coccidioidomycosis immunity is clinically measurable by the hypersensitivity reaction. Many of the above mentioned factors

however, have not yet been approached experimentally in coccidioidomycosis; the only one which seems certainly established is that acquired immunity does persist after the reaction to the intracutaneous test becomes negative through years of slow decline.

There is, however, one factor of tremendous potential importance in which coccidioidomycosis differs from other diseases. The delayed tuberculin type of reaction occurs in all instances as a response to the intracutaneous injection of various substances, all of them proteins with the single exception of coccidioidin, a protein-free polysaccharide. Thus, even if it becomes established that this reaction has no relation to immunity in all other instances, coccidioidomycosis may prove to be the exception.

It must be also pointed out that specific polysaccharides possess immunizing power in other diseases in which proteins do not. For example, pneumococcal polysaccharide will serve to immunize an animal without concomitant development of hypersensitivity; pneumococcal protein produces only hypersensitivity.

It is noteworthy that coccidioidin is usually produced by culturing the organisms in the same asparagine synthetic medium that is used for making tuberculin. Simple filtration yields only protein from cultures of tubercle bacilli grown in this manner whereas similar treatment of *Coccidioides* cultures produces only a protein-free polysaccharide. It is true also that additional antigenic substances such as polysaccharides and lipid may be obtained from the bodies of the tubercle bacilli themselves, by crushing or grinding the culture before filtration. But when *Coccidioides* cultures are treated in the same way, no new antigens are added to the filtrate. It is important to remember that it is pure tuberculoprotein that is the measuring stick in the tuberculin test; in the coccidioidin test it is a polysaccharide.

Also of interest is that the "acute splenic tumor" which occurs in many bacterial infections is not observed in coccidioidomycosis. In this reaction the spleen is filled with large mononuclear cells with large vesicular nuclei and basophilic cytoplasm which some observers consider to be phagocytes and others lymphocytes. The cause of this phenomenon is always a protein substance; some proteins can even produce it unaccompanied by infection. It would seem from these facts that coccidioides may not produce any specific protein while growing as a parasite in the animal body just as it does not do so when grown in artificial culture. This circumstance also lends credence to the belief that coccidioidin may fully represent all the antigenic potentialities of the fungus.

The great weight of experience with the complement fixation reaction, particularly as it applies to syphilis, makes it also seem heretical to claim that in coccidioidomycosis the degree of reaction is directly related to the severity of the disease and that by repeated tests the clinical course can be charted. That this view may still prove to be valid must be admitted, however, when the antigens are compared—or contrasted. In syphilis the antigen is not even remotely related to the disease nor to the organism which causes it; in coccidioidomycosis it is a pure extract of the organism. Furthermore the antigen in syphilis is a lipid and it ought not be assumed as inevitable that there should be similarities between the reactions evoked by it and the reactions caused by the polysaccharide antigen of *Coccidioides*.

WIDE RANGE OF TISSUE RESPONSE

The pathologic response in the tissues during the course of disseminated coccidioidomycosis is an unusual feature. When a mature spherule ruptures and discharges endospores an acute inflammatory response is induced in the immediate area with collection of myriads of polymorphonuclear leukocytes —a suppurative reaction. As each endospore enlarges, the reaction around it gradually becomes more chronic and lymphocytes replace the polymorphonuclear cells, then macrophages appear together with plasma cells and large mononuclear cells. Still more growth of the spherule produces an ever more chronic infiltrate until epithelioid cells predominate, finally assuming a tuberculoid structure with giant cells in the center where the mature organism is found with its endospores. When the spherule ruptures the entire cycle is repeated. Thus, the general appearance microscopically is that of a tissue reaction of mixed type, varying from the most acute in one tiny area to the most chronic in another close by. When to the series just described is added the eosinophilic infiltrate so characteristic of the allergic erythema multiforme stage of primary coccidioidomycosis, it is realized that this disease runs the entire gamut of non-neoplastic pathologic infiltrations. In tuberculosis, the tuberculoid structure is believed to be caused by the lipids produced by the bacilli. But can it be assumed that, during its life as an animal parasite, *Coccidioides* can produce lipids as the mature spherule stage is reached when it has never been observed to do so in culture?

In the majority of infections in which the mechanism is understood, it is evident that acquired resistance is the result of the formation of antibodies by the tissues as a result of contact with the organisms. These antibodies are highly specific globulins, apparently closely related chemically to the antigens which stimulated their production. The abilities of these antibodies to attach themselves to the organisms and cause them to become mutually

adherent, to interfere with their respiration or metabolism, and to cause them to be more easily attached to and engulfed by phagocytes, are integral parts of the immunologic process. Complement fixation, precipitation, agglutination, and lysis—frequently a single antibody can cause many of these reactions in appropriate circumstances. In only a few diseases can the antibodies actually destroy the organisms without the assistance of phagocytes.

A question yet to be answered is whether or not antibodies lead to immunity in coccidioidomycosis. In the study of this disease it is a handicap to be unable to produce the fungus in pure culture in the spherule stage in which it exists while a parasite in the body. Experiments in vitro with such material, if it were available, might uncover antibodies not yet recognized such as those capable of producing lysis, agglutination, opsonization or even destruction of the organisms directly. Spherules have indeed been produced in culture, but not separable from the mycelial form or from the complicated proteins necessary in the medium to support the spherule stage.

It must be assumed that there are some antibodies present in the infected body, for how else can be explained the specificity of the intracutaneous test and of the complement fixation and precipitation reactions? Also these antibodies must differ from each other since each is present in individually variable quantities and at different times. The antibody responsible for the complement fixation reaction, for example, cannot be useful in supplying acquired immunity, for its presence in increasing amount indicates a serious trend in the disease; also, immunity persists long after the antigen disappears. The antibody involved in the precipitation test is present for only a few months whether the patient is destined to die or to recover. That antibody, therefore, can have nothing to do with immunity. Both of these antibodies are present in serum and can be transferred passively, even through the placenta. The antibody responsible for the reaction to the intracutaneous test on the other hand, cannot be passively transferred. Hence it is logical that it is not present in serum. If that antibody is the one actually bringing about the development of acquired immunity it is strange that its presence is manifest principally in the skin where it is least needed and can function in the poorest manner. If assisting phagocytosis is its most important duty, then why, it must be wondered, does it not concentrate near the littoral cells of the spleen, lymph nodes and marrow and the Kupfer cells of the liver instead of close to the stretched-out endothelial cells of the skin capillaries which do not function as a part of the reticuloendothelial system, at least not immunologically.

Frequently when coccidioidin is introduced intracutaneously, there is immediate flare reaction and development of a wheal, indicating the presence of circulating antibodies. It has not been possible, however, to correlate this phenomenon with the acquisition of immunity or, indeed, in any specific manner with the disease itself. (Worthy of note in passing is that the spirochetal immobilizing antibody in syphilis is now known not to be concerned with immunity.) It cannot be definitely proved that antibodies are not present in the circulating blood, since without spherule cultures methods of detecting them are so inadequate. Attempts should be made to transfer a passive immunity by utilizing globulin fractions separated from the blood of immune persons by the several methods which have been perfected during recent years. Electrophoresis, the ultracentrifuge, Seitz filtration, lyophilization and chromatography should assist in the purification and identification of any such antibodies as may be found to exist. If by injection of an appropriate antibody a passive immunity could be conferred on those few persons who do not develop active immunity spontaneously, perhaps they could be kept alive long enough to do so.

Only immune serum from human donors could be used for the purpose. In chronic diseases antiserum from other animal species is useless, since the heterologous proteins induce antibodies against themselves which destroy or precipitate them within a short time after they are given in subsequent injections. Since antibodies are proteins, even if they could be highly purified they would still carry such species-specific antigenic power of self-destruction.

Since coccidioidal infection may be acquired only in small areas, and could occur from the inhalation of a single breath of dust by a visitor from distant parts, epidemiologic control by vaccination would be difficult to obtain even if methods could be discovered. So far there have been no successful attempts to induce active immunization in any animal to any disease which is already present in the body. All such methods act only to confer on normal animals the power to resist an original acquisition of the infection.

Except for those diseases in which toxins play a major role in injuring the patient and antitoxins delay death until active immunity develops, immunologic victories over chronic diseases are rare. Most of them depend upon adventitious cross-immunity between diseases or upon discovering or producing a special strain of the organism that has diminished power to produce injurious infection yet retains its immunizing potency. There has been absolutely no evidence to show any variation in virulence in various strains of *Coccidioides*. Even

the transfer through several different species of animals in the manner which recently brought yellow fever under control through the brilliant work of Max Theiler, does not noticeably vitiate the organism.

FIELDS FOR INVESTIGATION

Coccidioidomycosis resembles tuberculosis in many ways, yet a number of immunologic differences have already been pointed out. There are clinical differences also worthy of mention, which, since they have yet to be explained, may be appropriately expressed in the form of questions. Why does tuberculosis more seriously affect young females while coccidioidomycosis is much more harmful to males? Why does tuberculosis select certain racial groups for more drastic attack without regard to color of skin, for example the Negro, and Irishman, while coccidioidomycosis is less serious in all white races and more so in dark ones? (It must be stated, however, that Filipinos withstand the disease much less well than do persons of darker skinned races.) Why does coccidioides not involve the intestinal tract although sputum rife with organisms is swallowed, yet tuberculosis readily infects that region in similar circumstances?

These and many other questions remaining unanswered point to fertile fields for study. True, the discovery of an immunologic cure for coccidioidomycosis would not in itself be of world-shaking importance. However, as Arnold Rich so aptly said: "In the attainment of her ends Nature is often prodigal of materials, but she is always rigorously economical of methods." It is is almost certain that when all the facts concerning immunology are known, many of the mechanisms will be found to apply to all diseases. If even a small portion of the time, effort and expense which has been and is still being expended in the study of immunologic aspects of tuberculosis could be devoted to the study of coccidioidomycosis, a pathway might be blazed leading to the successful elimination not only of coccidioidomycosis but of the other granulomatous scourges of mankind. In California there are sufficient numbers of patients infected with *Coccidioides*, and here also are large numbers of immune persons, among whom are laboratory personnel not afraid to handle this dangerous organism. If one little barb of chauvinism be permitted (here comes the California gimmick) with the right amount of pecuniary support, California *might* initiate the conquest of granulomatous disease.

3875 Wilshire Boulevard.

Retroperitoneal Tumors in Children

Roentgen Diagnosis

HOWARD L. STEINBACH, M.D., and
REYNOLD F. BROWN, M.D., San Francisco

• *A study was undertaken to determine whether there are any features of retroperitoneal tumors in children that might be demonstrated on roentgenograms to aid in identifying them preoperatively. Study was limited to Wilms' tumor of the kidney and neuroblastoma.*

Calcification was found in 57 per cent of the neuroblastomas and in only 12 per cent of Wilms' tumors. Calcifications in neuroblastomas differed from those in Wilms' tumors. Calcification in neuroblastoma was more frequent in older children than in the younger ones.

The kidney was frequently displaced by both types of tumor. However, the neuroblastoma always displaced the kidney downward, or downward and slightly outward.

In most instances, the Wilms' tumor also displaced the kidney downward and outward, but in some instances upward and medially. This, of course, depended upon the site of origin of the tumor.

There was a distortion of the intrarenal structures in 75 per cent of the cases of neuroblastoma and in 71 per cent of the cases of Wilms' tumor.

THERE HAVE BEEN many publications in recent years describing the radiologic findings in retroperitoneal tumors of children, but none have analyzed the relative frequency of occurrence of these signs in large groups of patients. To determine if there are any characteristics which might aid in establishing a specific diagnosis, study was made of all of the available reports of cases of Wilms' tumors, or embryonal adenosarcoma, and neuroblastoma observed at the University of California Hospital, Children's Hospital in San Francisco and San Francisco Hospital. The study was limited to Wilms' tumor and neuroblastoma because other types of retroperitoneal tumors in infants and children are rare.

PATHOLOGY

Wilms' tumors account for about 20 per cent of all malignant diseases in childhood.[3] The origin of the tumor is believed to be from mesodermal cells displaced during development but retaining the ability to grow and differentiate into various types of tissue. At first, the tumor is surrounded by a dense, connective tissue capsule and remains separated from the renal parenchyma until it is quite large. Eventually the capsule is ruptured and extension occurs to renal tissue, omentum, and adjacent viscera. Blood-borne metastases are common in lungs, brain, liver and regional lymph nodes. Microscopically, the predominant tumor elements are an abundant embryonic type of malignant connective tissue surrounding the gland-like tubules of various sizes and shapes. Epithelial cells may also form solid cords and strands of cells. Sometimes a rosette-like arrangement of epithelial cells or structures resembling abortive glomeruli are seen. Occasionally, smooth or striated muscle, cartilage, and myxomatous tissue are present.

Neuroblastoma, or sympathicoblastoma, is a highly malignant tumor which arises in either the adrenal medulla or sympathetic nervous system. Microscopically it is an extremely cellular tumor composed of small, dark cells resembling lymphocytes. Characteristically, these cells form circular groups or pseudorosettes around a fine fibrillar network. The tumor metastasizes to liver, skull, dura, long bones and sometimes lung. Neuroblastomas which metastasize to the liver and soft tissues generally occur in younger children than those which metastasize to the skeletal system.[1]

MATERIAL

The present study was concerned with only the roentgen features of the primary retroperitoneal lesions. The metastatic lesions have been described adequately in previous publications.[2, 3, 4, 5, 6] There were 15 cases of proved Wilms' tumors and 14 cases of neuroblastoma in which adequate roentgen examinations had been carried out. Intravenous or retrograde urograms were performed on all of the pa-

From the Department of Radiology, University of California School of Medicine, San Francisco.

Presented before the 81st Annual Session of the California Medical Association, Los Angeles, April 27-30, 1952.

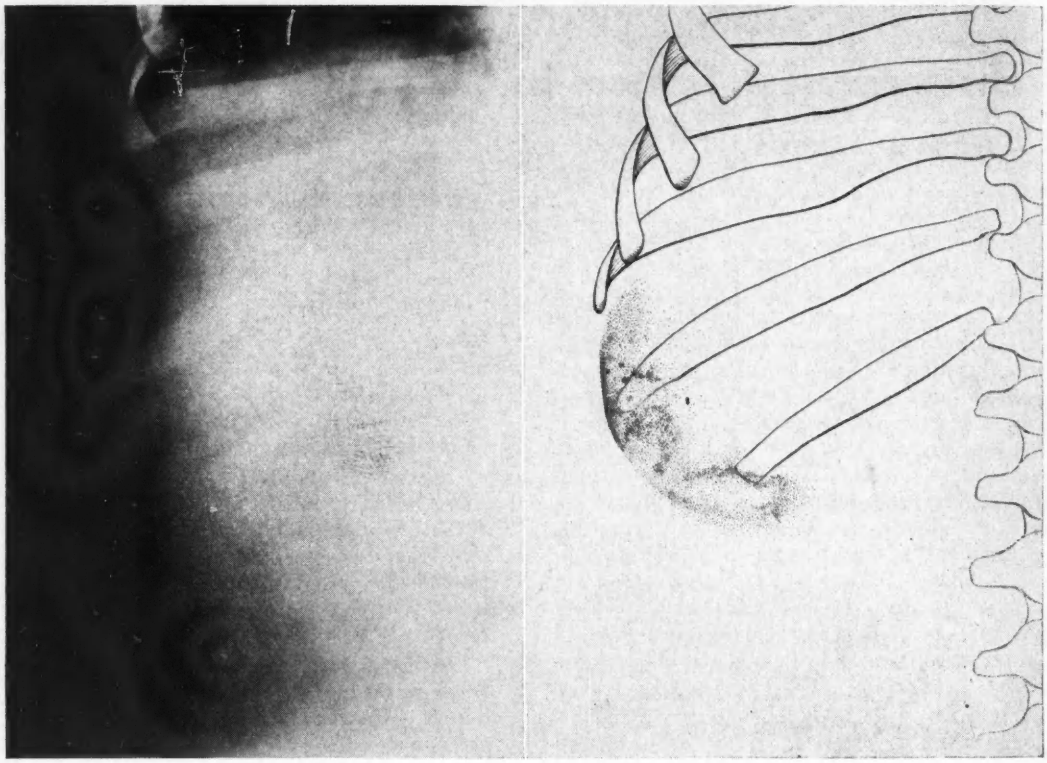


Figure 1.—Wilms' tumor containing calcium which is located in the peripheral part of the mass. The calcification does not reproduce well, but was dense, homogeneous, and arranged in concentric rings.

TABLE 1.—*Clinical Data on 41 Cases of Wilms' Tumor and 14 Cases with Neuroblastoma*

	Wilms' Tumor			Neuroblastoma (Present Series)
	Present Series	Higgins	Total	
Total	15	26	41	14
Male	10	11	21	6
Female	5	15	20	8
Right side	9	16	25	9
Left side	8	10	18	5
Average age	30 mos.	27 mos.	28½ mos.	36 mos.

tients who had Wilms' tumors and on ten of the patients who had neuroblastomas.

Of the 15 patients who had Wilms' tumors, five were females and ten were males. In a series reported upon by Higgins,[5] 15 of the patients were females and 11 were males. In the present series, the age of patients ranged from three days to ten years, with an average of two and a half years. This compares well with the average of two years three months in Higgins' patients. The right kidney was involved in nine patients and the left in eight. (Two of the patients had bilateral involvement, which accounts for the total of 17 tumors in 15 patients.) Higgins reported the tumor on the right side in 16 patients and on the left side in ten. Campbell[3] stated that Wilms' tumor has a predilection for the left side and for males, but gave no statistics.

Eight of the patients who had neuroblastomas were females and six were males. The tumor was located on the right side in nine cases, and in five cases on the left side. The patients were from five weeks to ten years of age; the average was three years (Table 1).

ROENTGEN EXAMINATION

Both types of tumor may cause roentgenographic evidence of a soft tissue mass with displacement of the viscera. Wyatt and Farber[9] identified a mass roentgenologically in all but seven of a total of 34 patients with neuroblastoma. However, the cases they studied were not limited to those in which there were abdominal lesions. A mass was demonstrated on plain films of the abodmen in all patients in the present series.

The relatively frequent appearance of calcification in neuroblastoma has been mentioned as an aid in differentiating it from other tumors in the retroperitoneal region.[2, 6, 8] However, little has been said

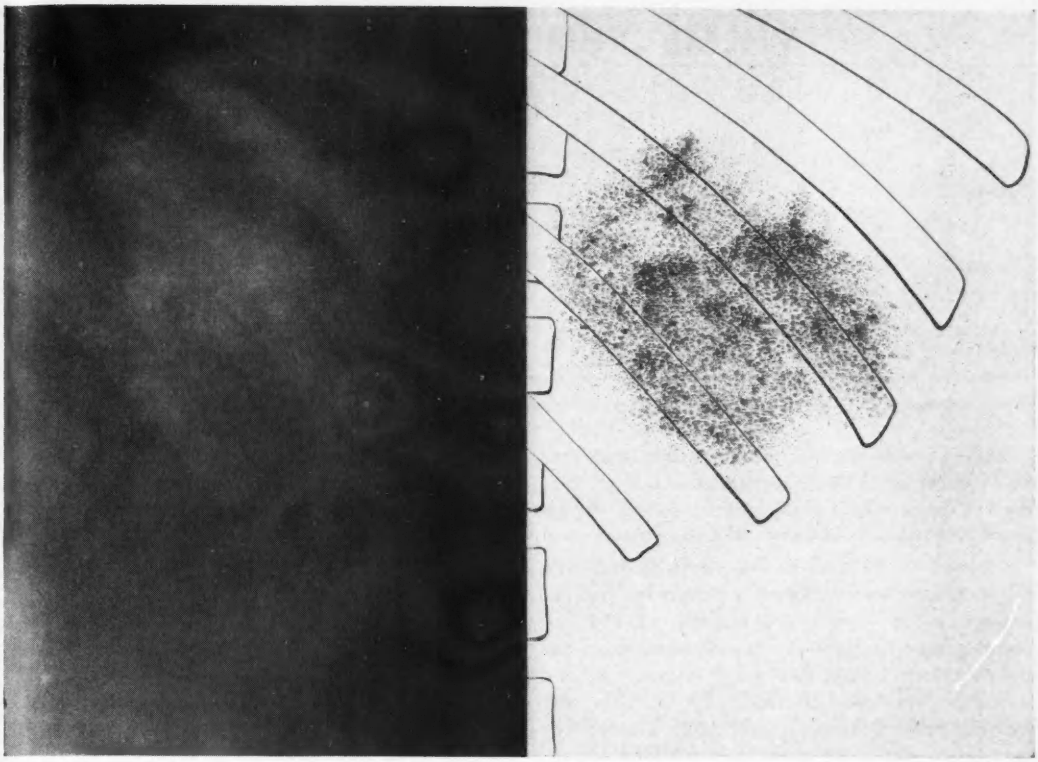


Figure 2.—Neuroblastoma containing calcium which produces a stippled or flaky appearance.

about the frequency of calcification in Wilms' tumor except to mention that it may occur.[5, 9] In the present study, calcification was observed in two of the 17 Wilms' tumors (12 per cent). The incidence of calcification was much higher in neuroblastoma; it was present in eight out of the 14 cases (57 per cent). Wyatt and Farber noted calcification in six out of 34 cases of neuroblastoma, and Parsons and Platt[11] in two out of six cases (Table 2). The average age of patients with calcified neuroblastoma was three years; for those without calcifications it was 1¾ years.

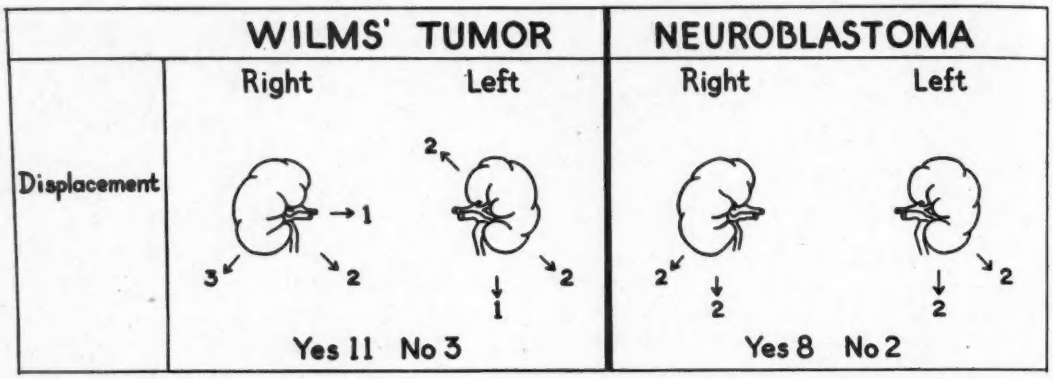
The type of calcification in the two diseases differed. In the two Wilms' tumors, the calcium deposits were located in the peripheral portions of the mass and consisted of dense, homogeneous, concentric rings (Figure 1). In six of the cases of neuroblastoma the calcification had a stippled or flaky appearance, not limited to the periphery of the mass (Figure 2), and in the remaining two cases there was a conglomeration of the calcium deposits in the tumor so that they appeared to form a dense, well-circumscribed lesion.

Urograms were obtained in all patients with Wilms' tumors. In 13 of the involved kidneys there was evidence of function: Contrast medium was present in the calyces and pelves after it was injected intravenously or subcutaneously. In four cases there was no roentgenologic evidence of function. The renal calyces and pelves were distorted in 10 of the 13 patients who had satisfactory renal function. One patient had only retrograde pyelograms, on which no evidence of distortion of the intrarenal structures was observed. The distortion in every instance appeared to be intrinsic in origin. The presence of distortion due to an intrinsic tumor was determined by the following: obliteration or elongation with either compression or dilation of a calyx; obliteration, dilation, or displacement of the renal pelvis and upper third of the ureter; and lack of evidence of excavation of renal parenchyma.

Urograms were made of ten patients who had neuroblastoma. The kidneys on the involved side functioned in all ten cases. Six of these patients had

TABLE 2.—*Incidence of Calcification in Wilms' Tumor and Neuroblastoma*

	Wilms' Tumor (Present Series)	Neuroblastoma			
		Present Series	Wyatt & Farber	Parsons & Platt	Total
Calcification	2 (12%)	8(57%)	6	2	16(30%)
No calcification	15	6	28	4	38



Displacement of Kidneys in 11 of 14 Cases of Wilms' Tumor and in 8 of 10 Cases of Neuroblastoma

evidence of distortion of the intrarenal structures and four did not. The distortion, when present, consisted of displacement of the calyces without elongation, obliteration, or dilation of these structures.

Eleven of the 14 involved kidneys in patients with Wilms' tumor were displaced appreciably. The displacements were: Upward and medially in two cases, downward and medially in two cases, downward and laterally in five cases, downward in one case and medially in one case (see chart). Two kidneys were displaced beyond the midline. It is obvious that the direction of displacement depends upon the site of the tumor. The authors' opinion, however, differs from the findings of Ward[10] who stated that renal tumors do not displace the kidney downward and medially.

Ward also stated that if a kidney is far removed from its normal position and functions well, the tumor may be benign and extrarenal. In two of the patients with Wilms' tumor in the present series the kidney was displaced beyond the midline and functioned well.

Eight of the ten patients with neuroblastoma had displacement of the ipsilateral kidney. In four cases it was displaced downward and laterally, and in four cases downward only.

University of California School of Medicine, San Francisco.

ACKNOWLEDGEMENT

The authors wish to express appreciation to Drs. Gordon G. King and A. Justin Williams for providing records of several cases included in this report, and to Dr. Henry Silver for his aid in conducting this study.

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Mediastinal Tumors of Thymic Origin

FREDERICK M. BINKLEY, M.D., JACK D. THORBURN, M.D.,
H. BRODIE STEPHENS, M.D., and ORVILLE F. GRIMES, M.D., *San Francisco*

• Twenty-one cases of mediastinal tumors of thymic origin are presented. Five of these were benign and 16 malignant.

Surgical excision is proposed as the treatment of choice for the encapsulated benign tumors or for malignant tumors of limited extent. When surgical excision is not feasible, adequate roentgen therapy amounting to 5,000 to 6,000 r calculated tumor dose may eradicate or control the tumor.

No correlation between the histological pattern of the tumor and the survival rate or radiation response could be demonstrated in this small series.

THE PROBLEM of thymic tumors has long been of great interest to clinicians and pathologists, no doubt owing to the incomplete knowledge about this gland. Many questions as to physiologic, pharmacologic, and pathologic factors lack conclusive answer. It is accepted that neoplasms of the thymus do occur and that the association of these tumors with myasthenia gravis is more than coincidental.[1, 5, 6, 10, 15] The majority of these tumors in patients having myasthenia gravis must be considered benign. It appears obvious that malignant thymic neoplasms occur not infrequently, but they are rarely associated with myasthenia.[9, 10, 11, 12, 13]

Seybold and associates[14] questioned the thymic origin of many of the previously reported malignant thymic tumors, as they found practically all tumors which they considered to be of thymic origin benign in character, both pathologically and clinically. However, the observations of the authors in 21 cases of such tumors were not in accord with those of Seybold and co-workers; in all cases sections were examined microscopically by numerous pathologists and all the neoplasms were considered to be of thymic origin. In no instance was there evidence suggesting that any of them could have been of bronchial origin or a teratoid tumor or a lymphoblastoma. In cases in which postmortem study was carried out, the impression gained at biopsy was confirmed.

PATHOLOGY

Pathological classifications of thymic neoplasms have been numerous and inconsistent.[2, 3, 4, 8, 16] Classification has been further confused by doubt over the origin of the small round cells in the thymus, now generally accepted as being lymphocytes.[7, 8, 16] Lowenhaupt[7] recently introduced a classification based on the epithelial derivation of the neoplasm, pointing out that most thymic neoplasms duplicate cell types seen in the stages of embryological development of the thymus and that a close relationship exists between the various groups. No classification can be entirely satisfactory, for in the majority of tumors there are varying histological structures throughout the neoplasms, but usually one type of pattern will predominate.

Lowenhaupt's classification is as follows:

Group I. Carcinoma of primitive epithelial reticulum (Figure 1-A).

Group II. Carcinoma of variegated cell pattern (Figure 1-B).

Group III. Carcinoma of the granulomatous pattern (thymic Hodgkin's disease) (Figure 1-C).

Group IV. Carcinoma of thymic round cells (Figure 1-D).

Group V. Encapsulated thymoma (Figure 1-E).

Group VI. Carcinoma of the adamantinomatous pattern (Figure 1-F).

Lowenhaupt felt that all groups must be considered malignant with the exception of Group V, which is benign. It appears that the vast majority of tumors reported in association with myasthenia gravis have been of this latter type and have shown lymphocytic infiltration which suggests greater maturity.[7, 9, 10, 11, 12, 13]

In the present series the tumor was considered malignant in 16 of the 21 cases and they have been classified by Lowenhaupt as noted in Table 1. Four tumors were unclassified because of wide variation in cell pattern. In autopsy examinations, performed in seven cases, extensive local infiltration was observed consistently, with extension into the neck region most frequently, and less often infiltration below the diaphragm. Rarely was extension into the axilla observed. In no case in the series was dis-

From the Department of Surgery and Division of Thoracic Surgery, University of California School of Medicine, San Francisco.

Presented before the Section on General Surgery at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

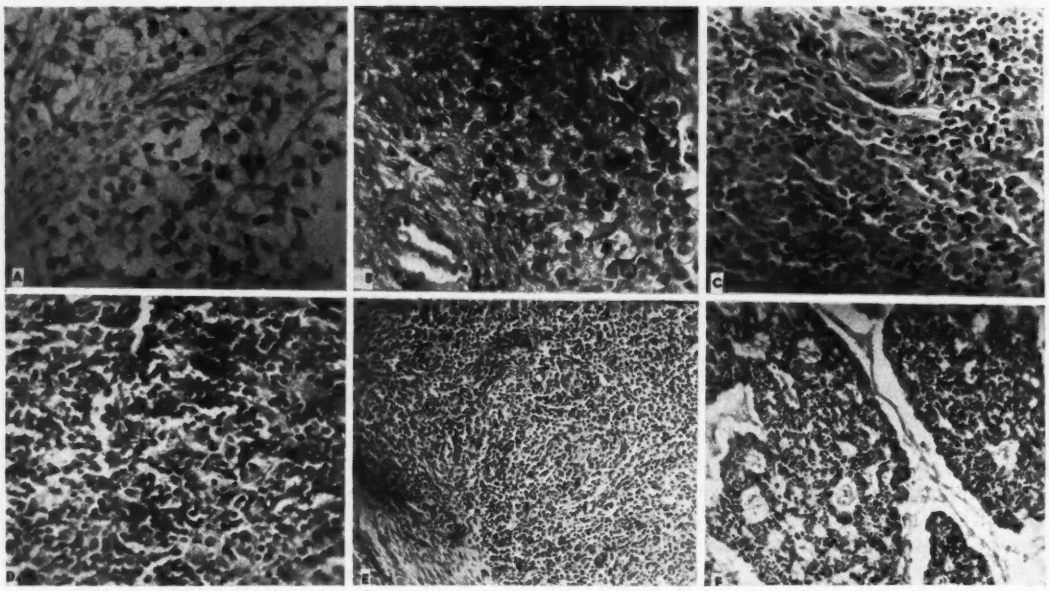

Figure 1.—*A*, Group I. Carcinoma of the primitive epithelial reticulum. This section, from the tumor in Case 1 (Table 1) shows the embryonal appearance and reticular nature of the cytoplasm of the tumor cells in this group.

B. Group II. Carcinoma of the variegated cell pattern. This section is from the same tumor as *A*, but shows the cell pattern seen in Group II. The fact that this picture came from a tumor which showed predominantly a reticular pattern indicates the close relationship of the various groups.

C. Group III. Carcinoma of the granulomatous pattern. This section, from Case 6, shows the lymphocytic and eosinophilic infiltration seen in this group of tumors.

D. Group IV. Carcinoma of the lympho-epitheliomatous pattern. This section, from Case 10, shows the lymphocytic infiltration and epithelial background of this group.

E. Group V. Encapsulated thymoma. Tumors of this group are seen most commonly in association with myasthenia gravis (Case 11).

F. Group VI. Carcinoma of the adamantinomatous pattern. It is felt that these cells spring directly from the primitive epithelial reticulum and that the pseudoglandular pattern can be explained by the close relationship of the anlage of the thymus to such neighboring organs as the parathyroids, salivary glands and enamel organs (Case 14).

tant metastasis noted, although such extension has been previously reported as an infrequent observation.[3, 8, 16]

CLINICAL ANALYSIS

The present series comprises 21 proved thymic tumors seen at the University of California Hospital from 1925 to 1951, of which 16 were considered malignant and 5 benign. In all cases the diagnosis was made from pathological study of the excised neoplasm or of a biopsy specimen obtained at the operating table. Eight of the patients were between 20 and 30 years of age (Table 2), and only four were in or past the sixth decade. Sixteen patients were examined because of symptoms referable to a mediastinal tumor, but in five cases the presence of the tumor was observed radiologically in routine or survey chest films.

Two patients were considered to have myasthenia gravis in association with the tumor. A woman, 61 years of age, noted symptoms characteristic of myasthenia gravis for six months before admittance for study. A dose of 210 mg. of neostigmine bromide orally daily established satisfactory control. Following surgical excision of a thymoma in 1946, the patient was greatly improved and although she returned to strenuous farm labor she remained completely free of symptoms while taking a maintenance dose of 30 to 75 mg. of neostigmine bromide daily. Another woman, 58 years of age, had noted progressive loss of strength and diplopia for one year. Neostigmine was not given. A thymoma (Figure 2) was removed in 1945 and the patient had no further complaints. The diagnosis of myasthenia gravis in that case must be considered as presumptive. No other patients in the group had symptoms of sufficient magnitude to warrant a clinical diagnosis of myasthenia gravis.

Surgical excision was attempted in 14 of the 21 cases and in seven a biopsy specimen of the neoplasm was obtained. Four of the excised tumors were obviously incompletely removed and each of them was considered malignant. Five of the ten tu-

TABLE 1.—*Clinical, Therapeutic and Pathologic Data on 21 Cases of Mediastinal Tumor of Thymic Origin.*

Case	Age	Sex	Diagnosis	Group	Therapy	Follow-up	Autopsy Report	Remarks
1*	24	M	Carcinoma	I	Radiation 3000 r	Died 9 years after therapy	No remaining tumor	Specimen obtained from biopsy
2*	50	M	Carcinoma	I	Excision	Postoperative mortality	Local infiltration No metastases	Excision incomplete
3*	45	M	Carcinoma	I	Radiation 1000 r	Died 3 months after therapy	No autopsy	Specimen obtained from biopsy
4*	42	F	Carcinoma	I	Excision Radiation 2000 r	Died 1 year after therapy	No autopsy	Excision incomplete
5*	24	M	Carcinoma	I	Excision Neutron ther.	Died 5 months after operation	No autopsy	Excision incomplete
6*	24	M	Carcinoma	III	Radiation 5750 r	Alive 2 years after therapy		No evidence of tumor
7*	28	F	Carcinoma	III	Radiation 2500 r	Died 3 years after therapy	Extensive local infiltration. No distant metastases	Inadequate radiation due to erroneous initial diagnosis
8*	30	F	Carcinoma	III	Excision Radiation 1 yr. later; 3050 r	Alive 2 years after radiation		Secondary tumor in lung excised with primary tumor
9*	28	F	Carcinoma	III	Excision Radiation 3120 r	Cervical recurrence, lt., 6 mo. rt. 9 mo.; radiation		Alive. No evidence of recurrence 2 yrs. after radiation
10*	23	M	Carcinoma	IV	Excision Radiation 3600 r	Recurrence 1 yr. after operation	Extensive local infiltration. No distant metastases	No tumor in areas irradiated at autopsy
11*	64	F	Thymoma	V	Excision	Symptoms improved		Clinical symptoms myasthenia gravis
12	46	F	Thymoma	V	Excision	Asymptomatic		
13*	58	F	Thymoma	V	Excision	Symptoms alleviated		Symptoms suggested myasthenia gravis
14*	40	M	Carcinoma	VI	Radiation 1945 3000 r Excision 1948	Postoperative mortality	Local infiltration No metastases	No regression of tumor with radiation therapy
15	63	M	Carcinoma	VI	Excision Tumor adherent to pericardium	Died 3 months after operation	Local infiltration No metastases	History recurrent pericardial effusion 3 years
16	63	M	Carcinoma	VI	Biopsy	Postoperative mortality	Tumor adherent to superior vena cava and pericardium	
17*	45	M	Carcinoma	VI	Excision	No recurrence in 5 years		
18	20	F	Carcinoma	?	Excision Radiation 5300 r	Asymptomatic 2 years after therapy		No evidence of tumor
19	33	M	Carcinoma	?	Radiation 2700 r	Died 2 months after therapy	No autopsy	Specimen obtained from biopsy
20†	37	F	Chori-stoma	Be-nign?	Excision	Asymptomatic 1½ yrs. postop.		Tumor located at interlobular septum
21	33	M	Cyst of thymus	Be-nign?	Excision	Asymptomatic 3 yrs. postop.		

* These cases previously reported by Lowenhaupt.[7]

† Case report to be published.

mors clinically completely excised were classified as benign. There were three postoperative deaths, two after incomplete excision of the tumor and one after excision of material for biopsy.

The majority of the operative procedures were done through a posterior lateral incision, which is the approach of choice especially for large tumors.

TABLE 2.—*Age of Patients at Time of Study*

Age	Total	Tumor	
		Benign	Malignant
20-30	8	0	8
31-40	3	2	1
41-50	6	1	5
51-60	1	1	0
61-70	3	1	2

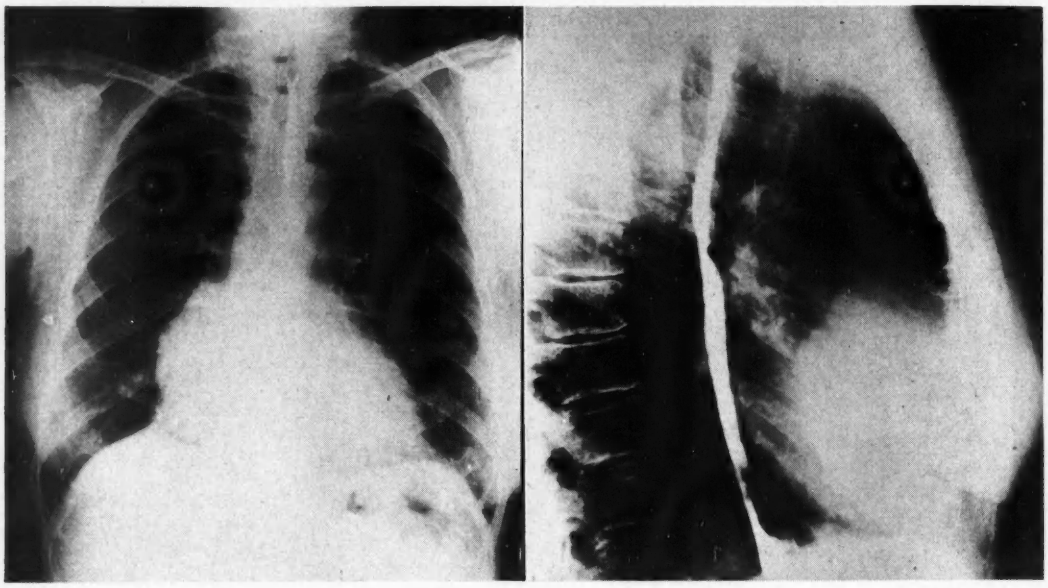

Figure 2.—Anterior mediastinal tumor best seen on the lateral projection (Case 13). Symptoms suggestive of myasthenia gravis were relieved by excision of the tumor which proved to be a benign thymoma.

The vertical or transverse sternal-splitting incision provides admirable exposure for all save the largest of tumors. In one instance a transverse sternal incision at the level of the nipples was combined with a necklace incision to expose the uppermost extension of the thymic tumor and the cosmetic result was excellent.

Roentgen therapy was given to 12 of the 16 patients with malignant thymic tumor. The pattern of therapy has varied considerably during the years of this study. In one case, neutron therapy consisting of 425 n through three separate fields was administered. Five patients received less than 3000 r calculated tumor dose in one series of treatments. In four cases 3000 to 3600 r was given over a period of 28 to 40 days. Recently the amount of radiation has been increased considerably and the last two patients treated by roentgen therapy were given a calculated tumor dose to the anterior mediastinum of 5300 r over a period of 38 days, and 5750 r in 48 days, respectively (Tables 3 and 4).

Of the 21 patients who were treated by operation or roentgen therapy, or both, ten were living, well and asymptomatic at the time of this report. Five of the ten were considered to have had benign tumors, three of them thymomas, one a thymic choristoma arising from a cell rest in the hilus of the left lung, and one a cyst containing thymic remnants in its wall. All of these benign tumors were completed excised, and the patients with thymomas had no evidence of recurrence five, six and eleven years after operation. The thymic cyst was removed three years ago and the choristoma in the past year.

The remaining five living patients had tumors that were classified as malignant. Three were classified as Group III by Lowenhaupt, one as Group VI, and one was unclassified because of the wide variation of cell pattern throughout. Three of the patients were operated upon for removal of the tumor, but excision was incomplete in one case and radiation therapy was given postoperatively. The two patients

TABLE 3.—*Treatment of Malignant Tumors*

	Living	Died	Total
Excision alone	1	3*	4
Biopsy or excision plus x-ray <3000 r		6**	6
Biopsy or excision plus x-ray >3000 r	4	2†	6
Total	5	11	16

* Two died in postoperative period. ** One died in postoperative period. †No tumor found in treated area at autopsy.

TABLE 4.—*Therapy of Malignant Tumors*

	Alive	Dead
Complete surgical excision only	1	1
Clinically complete excision and roentgen therapy	1	1
Clinically incomplete excision and roentgen therapy	1	2
Biopsy and roentgen therapy	2	4*
Operative mortalities		3

* In one case no tumor was observed at autopsy 9 years after therapy.

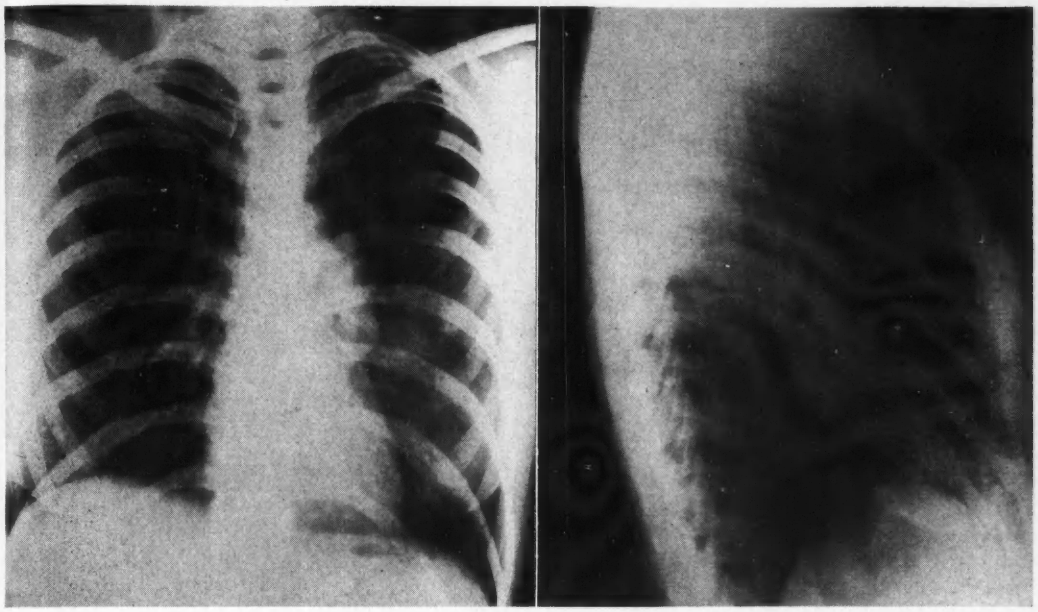

Figure 3.—Anteroposterior and lateral views of anterior mediastinal tumor which proved to be Group III (Case 8). A metastatic nodule in the left upper lobe not shown by x-ray was also excised at the time of removal of this tumor.

who were not operated upon had roentgen therapy after the nature of the tumor had been determined by biopsy.

One patient, a 30-year-old woman, had recurrence of tumor despite apparently complete excision. The seemingly encapsulated anterior mediastinal tumor (Figure 3) was relatively easily dissected free except for one area densely adherent to the pericardium which was excised with the tumor. In addition a circumscribed tumor 2 by 2 cm. in size in the upper portion of the left lower lobe was also resected. Both the primary and the metastatic nodule were considered malignant, but since they were grossly completely excised postoperative roentgen therapy was not given. A year later increased mediastinal density noted in an x-ray film of the chest was interpreted as a probable recurrence. Roentgen therapy was administered and the calculated mediastinal dose at the depth of the probable recurrence was 3020 r. At last report the patient had remained asymptomatic for two years after conclusion of therapy and no abnormality was observed in a film of the chest.

Complete excision of an apparently encapsulated tumor was readily accomplished in another patient, a 45-year-old man. The neoplasm was classified as a carcinoma of adamantinomatous pattern (Group VI). Postoperative radiation was not given. The patient remained asymptomatic and no evidence of recurrence was observed in a film of the chest more than five years after excision of the tumor.

Another of the three living patients with malignant tumors who were surgically treated, a 28-year-old woman, had a large anterior mediastinal tumor apparently arising in the right lobe of the thymus. The tumor was densely adherent to the innominate vein and vena cava and it was apparent that complete excision was not obtained. The left lobe of the thymus was identifiable in continuity with the tumor mass and was histologically normal, while the right lobe was replaced by tumor (Group III). Postoperative roentgen therapy was administered and the calculated tumor dose was 3120 r. Six months later a biopsy specimen was obtained from a left supraclavicular tumor mass which proved to be a recurrence of the thymic neoplasm. Roentgen therapy totalling 3922 r was given to this area and the mass disappeared. Three months later a small mass which appeared in the right supraclavicular area was also irradiated with a similar dose. This mass also disappeared and, at last report, two years after the last radiation therapy, the patient had no clinical evidence of recurrence.

One of the two living patients with malignant tumor who were not operated upon had a palpable mass in the left supraclavicular area at the time of admittance, in addition to a large mediastinal tumor visible in x-ray examination (Figure 4). After biopsy, roentgen therapy was administered. The calculated tumor dose in the mediastinum was 5750 r administered over 48 days and the dose to the left

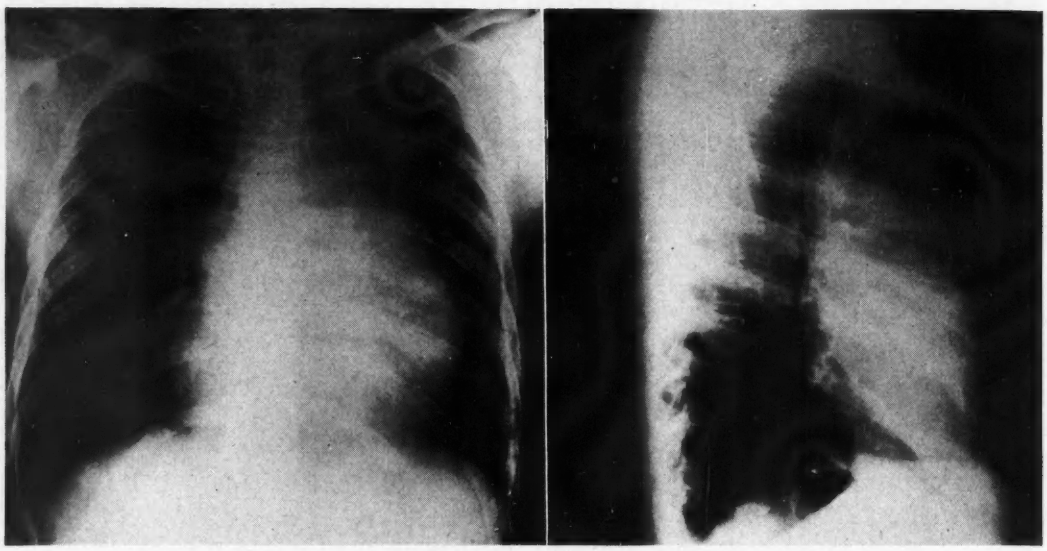

Figure 4.—Anteroposterior and lateral views of tumor classified as Group III (Case 6).

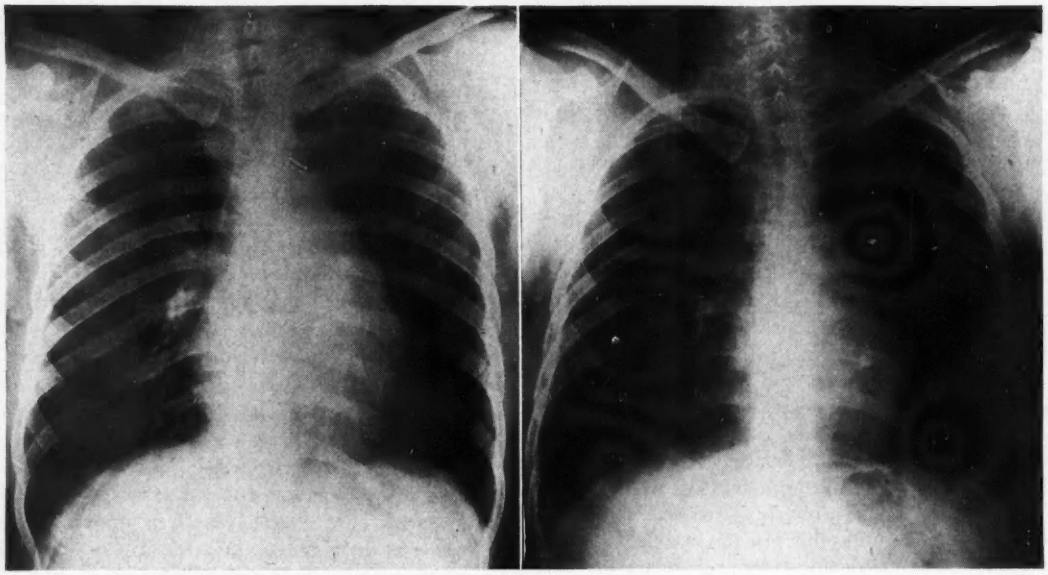

Figure 5.—Same patient as in Figure 4. *Left,* immediately after roentgen therapy of 5750 r calculated tumor dose. *Right,* complete disappearance of the tumor a year and a half later.

cervical area was 3000 r. The tumor rapidly regressed in size and at last report the patient had had no evidence of recurrence during the two years following completion of the radiation therapy (Figure 5).

The other of the two living patients with malignant growth who were not subjected to operation was a 20-year-old woman with a large anterior mediastinal tumor extending into the left supraclavicular fossa. By biopsy it was diagnosed as a thymic carcinoma, as yet unclassified. Roentgen therapy was given. The calculated tumor dose was 5300 r administered over 38 days. There was no evidence of tumor growth two years after completion of the therapy.

Eleven of the patients with malignant thymic tumors died, three of them in the postoperative period, as was previously mentioned. It is worthy of note

that one of the three (who had a Group VI tumor) received roentgen therapy amounting to 3000 r three years preoperatively and 1850 r again one year preoperatively without noticeable change in the rate of growth of the tumor. The patient died a few days after attempted excision of the tumor.

One patient (with Group I tumor) who was treated early in the series lived nine years after completion of roentgen therapy of approximately 3800 r. Postradiation fibrosis developed and it was complicated by bouts of massive hemoptysis. The patient died during exploratory thoracotomy done in hope of relieving the complication. At postmortem examination there was no evidence of residual tumor.

Another patient (with Group VI tumor) died three months after attempted excision of the tumor without receiving roentgen therapy. Two of the patients (one with Group I and the other with Group III tumor) who received over 3000 r died of extension of the disease, but at postmortem examination there was no evidence of tumor in the treated areas.

In four cases autopsy examination was not done. Three of the four patients received considerably less than 3000 r of roentgen therapy and one received neutron therapy as previously noted. In three of these cases the tumors were classified as Group I, and in the other the cell pattern was so variable as to be unclassifiable.

DISCUSSION

In this limited series no correlation can be demonstrated between survival rates and pathological pattern of the tumor, nor can any conclusion be drawn as to optimum roentgen therapy for the various classes of tumors (Table 5). However, observations in these few cases suggest that the neoplasms are primarily locally invasive and that remote metastases occur infrequently. Therefore, early adequate operation would appear to offer hope of good results, such as were obtained in the case of the one patient with malignant disease in the present series who had adequate excision.

The postoperative deaths in this series should not discourage the surgical approach, for two of them occurred early in the series before the advent of antibiotics and present-day anesthesia, and in the third case the patient was already moribund from superior vena cava obstruction. The authors believe that all undiagnosed anterior mediastinal tumors warrant surgical exploration and, if resection is not feasible, a biopsy of the tumor to determine the advisability of roentgen therapy.

The four patients surviving two or more years after radiation therapy all had calculated tumor doses of more than 3000 r, and study of those cases and the two cases in which no tumor was observed in the treated area at necropsy suggests that some of these tumors may be eradicable or controllable by roentgen therapy. In recent years 5000 to 6000 r has been administered over a period of 30 to 40 days with encouraging results.

TABLE 5.—*Results of Treatment of Malignant Tumors*

Classification	Treatment: Excision	Treatment: Excision & X-Ray	Treatment: Biopsy & X-Ray	Results: Living	Results: Died
I	1*	2	2	0	5
III		2	2	3	1
IV		1			1
VI	2*	1	1*	1	3
Unclassified		1	1	1	1

* Postoperative death.

As these neoplasms are not manifested by subjective complaints until they have reached a considerable size, diagnosis while they are in an early resectable stage will depend largely upon survey and routine x-ray examination of the chest. An unexplained mediastinal density should be viewed with a high degree of suspicion.

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Is it Neurosis?

JOHN PETERS, M.D., Los Angeles

• *So-called "minor psychiatry," the treatment of neurosis in persons who are not psychotic, may well be undertaken by the general practitioner.*

The first duty of the physician in dealing with a neurotic person is to determine whether psychosis may develop. He must be patient and thorough in hearing the history of the case and should have full information on the patient's life and family.

A recent classification of the neuroses is given and the more generally recognized symptoms of these conditions are described.

FOR SEVERAL YEARS, according to Levine,[2] it has been possible to speak of "major psychiatry" and "minor psychiatry" as we speak of major and minor operations. The major surgical procedures should be undertaken only by those who are fully trained and experienced, but it is recognized that there are also certain types of operation which can be performed by the practitioner with less specialized training with equally satisfactory results. An analogous situation exists in psychiatry: The great majority of nervous conditions fall into the "minor" category and do not require treatment by a specialist. This presentation is an attempt to give information that may be of value to the general practitioner in determining whether a patient has a functional disorder (neurosis).

It has been firmly established that every emotional conflict has some physiologic or organic concomitant, and it is also true that every organic disturbance causes emotional symptoms. Alexander[1] put it well when he said that theoretically every disease is psychosomatic since emotional factors influence all body processes through nervous and humoral pathways. He cited common physiological processes such as weeping, sighing, laughing, blushing, gesticulating and grimacing which can take place only under the influence of specific emotional situations.

Watts and Wilbur[4] recently stated that any diagnosis in patients with functional disorders requires identification of symptom complexes resulting from functional disorders as well as from organic disease. Although they used the word "functional" throughout their discussion it is obvious that they were referring to disorders stemming from neurosis.

In recent years the terms "neurosis," "psychoneurosis," and "psychoneurotic reaction" have become synonymous. All denote physiologic reaction to situational problems. It has been said that neurosis does not deny the existence of reality, it merely tries to ignore it. The reactions are unconsciously motivated, or at least they are out of voluntary control. The symptoms reflect individual ways of reacting to specific stresses and they vary according to constitutional equipment and experience of life. Neurosis stems from efforts to deal with specific difficult and anxiety-producing emotional problems. It is well to remember that all persons have emotional symptoms, but it is only when the symptoms are bothersome, or cause anxiety with physiological changes, that it becomes necessary to remedy them.

In dealing with a patient having symptoms of neurosis the most important thing for the physician to determine is whether the condition might develop into psychosis. In neurosis there is but little disorganization of the personality, whereas in psychosis the disorganization is relatively great. The inner experiences of a neurotic person do not upset the external behavior, but the behavior of a psychotic person may be entirely abnormal. It should be noted, however, that a diagnosis of psychosis can never be made on the basis of behavior alone. The thought content must be considered along with behavior deviations. In neurosis the grasp of social relations is not disturbed and there are no real delusions, whereas in psychosis frequently social adjustments are destroyed and true delusions occur. A person who is only neurotic has no disturbances of associations; there is no consistent or lasting deterioration of the intellect; insight is usually good and regression is not present or is only slight. In contrast, in psychotic persons, associations usually are distorted or impaired; deterioration of the intellect may be pronounced; usually insight is lacking, and, as in senile or paretic patients, regression may continue to the infantile level.

CLASSIFICATION

The general practitioner may have no great interest in the formal classification of the neuroses. However, one can recognize only that with which he is

From the Department of Psychiatry, Section on Nervous Diseases, College of Medical Evangelists, Los Angeles.

Presented before the Section on General Practice at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

familiar. If a person knows little or nothing about the shadings in an x-ray film he will learn little or nothing from them. If signs of pathologic changes are pointed out to him in a film, he may recognize them but will still be unable to associate them with the total picture.

Applying the same logic to skin diseases, it becomes clear that the physician must know the type of rash or lesion to be expected before he can get a good idea of the diagnosis. This may be quite difficult at times. Differences of opinion may be expressed by even the most skilled of diagnosticians, but if they have sufficient knowledge of the classification of the diseases, diagnosis is made easier. Differences of opinion do not imply that a classification is not desired. Systematic arrangement tends to make for a more rapid absorption of content material.

The latest classification of the neuroses has appeared only recently. Doubtless the old terms will continue in use for many years to come. But no matter what nomenclature is adopted by the American Psychiatric Association, every effort should be made to adhere to the terms selected. This uniformity averts the misunderstanding and confusion which would otherwise result from the use of different terms by various groups or persons.

OLD TERMS	NEW TERMS
1. Hysteria	1. Anxiety reaction
a. Anxiety	2. Dissociative reaction
b. Conversion	3. Conversion reaction
2. Psychasthenia	4. Obsessive-compulsive reaction
3. Neurasthenia	5. Depressive reaction
4. Hypochondriasis	6. Phobic reaction
5. Reactive depression	7. Psychoneurotic reaction, other.
6. Anxiety state	
7. Mixed types	

The American Psychiatric Association has recently published a manual which includes the new nomenclature and indicates the old where changes have been made. Students of psychiatry will wish to consult this manual whether they are specialists or general practitioners. "Neurasthenia" and "hypochondriasis" are replaced by a new classification known as "psychophysiological reactions." "Anxiety reaction" replaces the old "anxiety hysteria" and "anxiety type." "Conversion reaction" replaces "conversion hysteria." "Obsessive-compulsive reaction" replaces the psychasthenias, and "depressive reaction" replaces "reactive depression." "Psychoneurotic reaction, other" permits other classifications if the examiner cannot place his findings in any of the stated categories. It replaces "mixed" type in the old classification. "Dissociation," as described by Noyes, is a mechanism to the employment of which the organism may resort in order to secure a measure of satisfaction when various components of the personality are not well integrated. An aspect of the personality that is a source of emotional distress may thus be eliminated. Examples of dissociation are sleep walking, automatic writing, fugues and multiple personalities.

ETIOLOGY

An accurate diagnosis cannot be made without some idea of the causative factors. Books have been written in an endeavor to show that a neurotic patient is neurotic because he has a poor hereditary background, and still other books have been written to show that what happens to a person after he is born constitutes the deciding factor in the development of neurotic traits. It is reasonable to assume that both heredity and environment play a part. The constitutional factors may be compared to soil which may be rich or poor in qualities which make for the development of neurotic traits or tendencies; and the happenings of life, whether stresses, strains, tensions, conflicts, guilts, wishes, frustrations or violations of taboos, may be likened to the seed.

Continuing the analogy, it is recognized that there must be soil and there must be seed, and the seed must be dropped in the soil before there can be a disruption sufficient to disturb the person's tranquility. Emotional factors cannot be ignored as causes in the development of a neurosis, but neither can the constitutional equipment be passed over lightly. Many adherents to the psychoanalytic approach to the neuroses believe that they are basically derived from the conflicts that arose in childhood. Other experts differ with this theory. Probably everyone will agree that without psychological conflict neurotic symptoms would never develop sufficiently to cause disability.

SYMPTOMS

It has been said that a hysterical patient may have symptoms simulating those of any disease. This may be an exaggeration, but it gives an idea of the wide variation in symptoms in hysteria. The disturbances may be sensory, motor, visceral or mental. Where there is a multiplicity of somatic complaints without substantiating physical findings, or with bizarre findings, the diagnosis of hysteria must be considered. When anxiety, worry, fright, startle patterns and panic reactions are predominant, anxiety reaction is a more likely diagnosis. If there are compulsions, obsessions or phobias, the classification of obsessive-compulsive reaction is obvious. (A *phobia* is an intense fear associated with an idea, object or situation which tends to recur. *Obsessions* are thoughts of a distressing or unwelcome nature that tend to recur and are regarded as defensive in pur-

pose. *Compulsions* are usually confined to some action performed under an irresistible urge.)

The depressive reaction deserves special comment. It is always directly associated with some disturbing event in the life of a person who has been somewhat neurotic for years, and may follow a disappointment in love, financial reverses, severe illness, divorce, a death or any emotionally charged situation. There is always the possibility of suicide in such a case, and for this reason consultation should be obtained early, not necessarily with a psychiatrist but with any other physician.

DIAGNOSIS

No diagnosis of neurosis can be made without a good history of the case, and the physician should not expect to get a good history without devoting considerable time to listening. In many cases the diagnosis can be made, or at least a good lead obtained, by listening alone. It may be necessary to interject leading questions at certain points in order to get a longitudinal view of the patient. The physician must strive to get as much information from the patient, friends or relatives as possible, and this background must include the family history back at least as far as the grandparents. An attempt should be made to determine whether the childhood was happy or not, and whether the patient felt that he was loved, wanted and secure.

Certain highly significant traits have been designated as the "neurotic stigmata" of childhood. Any child may have some of them, but if a child has more than four or five it is quite probable that neurosis will develop. These traits are:

Fainting attacks
Nail biting or picking
Temper tantrums
Worry
Dizziness
Handicaps: crossed eyes, harelip, limp, etc.
Sleepwalking
Sulking
Enuresis
Stammering
Thumb or finger sucking
Slow to walk or talk
Convulsions
Nightmares
Habit spasm
Tics
Fears of: Dark, storms, heights, crowds, closed places, animals, etc.

The physician should ascertain whether, as he grew older, the patient had a tendency to be shy, bashful, forward, seclusive, asocial, moody, depressed, or eccentric or had crying spells, whether it was easy or difficult for him to make and hold friends, develop hobbies and get along with others, and if not why not.

The following neurotic traits, although they sometimes occur in children, are more often observed in adults:

Headache
Globus
Hyperhidrosis
Formication
Introspection
Heart consciousness
Tremors
Backache
Twitchings
Head noises
Tenseness
Apprehension
Dyspnea
Anorexia
Muscle ache
Dermographia
Insomnia
Anxiety
Palpitation
Numbness
Fatigue

A few points in which neurotic symptoms differ from those of an organic nature should be kept in mind. If a patient has paralysis of some kind over which he has but little concern or anxiety, a functional element is to be suspected. When the complaint is of fatigue out of all proportion to the amount of physical effort performed and not owing to organic causes, neurosis should be considered. The time of onset of anxiety-producing symptoms is important, as there may have been some definite, unusual event which occurred such as head injury, personal loss, fever, infection, etc. The physician should be quick to note whether the symptoms are out of all proportion to the trauma, physical or mental, and to learn if the patient ever injured himself previously in a similar way. The inferences to be drawn are obvious.

Finally, it must always be remembered that there is no substitute for a thorough physical examination, whether it be for diagnosis or for therapy in neurosis.

312 North Boyle Avenue.

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Measurement of Thyroxin Synthesis with I^{131}

A Test for Evaluation of Thyroid Function in Equivocal States

M. E. MORTON, M.D., Ph.D., *Long Beach*

• *As the function of the thyroid gland is the synthesis and secretion of thyroxin, a test which correctly measures this process is best for diagnosis of thyroid disorder and for determining the success of therapy. The rate of secretion can be measured with a Geiger counter which indicates what proportion of radioactive iodine in a serum specimen is in the form of thyroxin. The normal proportion is 2 to 10 per cent; in hyperthyroidism the proportion is 50 to 70 per cent, and in hypothyroidism less than 1 per cent.*

The same test has served to detect metastases of thyroid carcinoma following total thyroidectomy.

A CLASSICAL CASE of toxic goiter or of myxedema is not likely to require laboratory tests for diagnosis. Sufficient signs and symptoms are manifest in these states so that they are rarely overlooked by the physician. However, between these extremes of thyroid function there is a wide range of variation in activity of the gland, and within this range many cases of dysfunction are difficult to diagnose. Furthermore, hypermetabolic and hypometabolic disorders may be erroneously diagnosed as thyroid disease unless adequate laboratory studies are made. Laboratory procedures designed to aid in the correct diagnosis of thyroid disease are many, but few are simple enough for routine use and even fewer are sensitive enough for accuracy.

The test of basal metabolic rate as usually performed may give variable results. Particular attention must be given to the basal state of each patient, for even if conditions are ideal, diagnosis is often difficult in a given case because of the wide range of results in normal persons.[1, 2]

Determination of the amount of cholesterol in the blood has proved of little value in the diagnosis of hyperthyroid states, although it is of some value as a control measure in the treatment of hypothyroidism. For this test also there is a wide range of normal values, and the results are not specific for thyroid disease.[1, 9]

A similar criticism can be made even of the chemical determination of protein-bound iodine in the serum or plasma (Chart 1). Part of this lack of sensitivity may be attributable to the technical difficulties inherent in the analysis of extremely small amounts of iodine. In addition, conditions unrelated to thyroid abnormality such as pregnancy or nephrosis may cause results outside the normal range.[6, 10]

It has been suggested that the concentration of circulating thyroxin is the best measure of function of the thyroid gland. However, the level of concentration is a result and not the prime determinant of the rate of synthesis of thyroxin. It is the measurement of the actual speed of synthesis and secretion of thyroxin which should prove a more accurate indicator of glandular function. Further, there is evidence that the protein-bound iodine consists of not only the active hormone, thyroxin, but also organic iodine compounds of undetermined calorigenic activity.[4] Conditions increasing or decreasing the concentration of these other compounds in the blood could also contribute to the wide variation and overlap found in protein-bound iodine measurements.

Radioactive iodine has been widely used in recent years in the evaluation of thyroid function. With

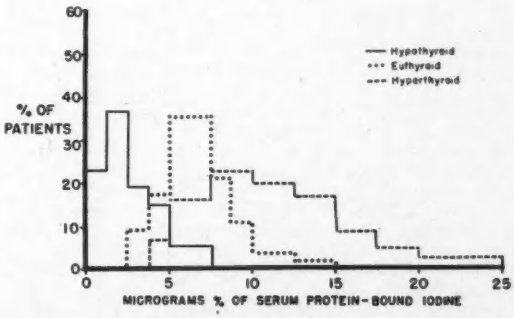

Chart 1.—Distribution of values for protein-bound iodine in the serum in 200 studies of patients with varying states of thyroid function. A significant degree of overlap can be observed.

From the Radioisotope Unit, Veterans Administration Hospital, Long Beach.

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Presented before the Section on General Medicine at the 81st Annual Meeting of the California Medical Association, April 27 to 30, 1952, Los Angeles.

The radioiodine used in this investigation was supplied by Oak Ridge National Laboratory on authorization from the Isotopes Division, U. S. Atomic Energy Commission.

measurements of radioactive iodine, the limitations and variabilities of chemical methods of iodine analysis are avoided. Only emitted rays are measured. With the average Geiger counter less than a billionth of a microgram of radioiodine can be readily measured.

The measurement of the uptake of radioiodine by the thyroid gland over a period of 24 hours has been the most extensively used,[8] but results just as good have been obtained recently with one-hour uptake tests.[3, 5] However, difficulty is encountered in diagnosing cases even with uptake tests. The range of uptake in normal persons considerably overlaps the rates found in hypothyroid and hyperthyroid patients.[7] Chart 2, showing the distribution of uptake values observed in some 500 studies, indicates that the uptake of circulating iodide by the thyroid is not always a measure of thyroid hormone formation and secretion and therefore may not accurately depict overall thyroid function.

Thyroxin is stored in the follicles of the thyroid gland in the colloid protein, thyroglobulin. Under the influence of the thyrotropic hormone of the pituitary gland, thyroglobulin is hydrolysed and thyroxin is secreted as the amino acid into the blood. This process may be followed with radioactive iodine, which serves as a label of the endogenous circulating iodide, tracing its movement through the sequence of reactions which lead to the secretion of thyroxin from the thyroid into the bloodstream. The thyroxin synthesis test is a measure of the speed with which these processes take place. The results of the test are expressed as the percentage of radioactive iodine in the serum which is in the form of thyroxin.

Twenty-four hours after the oral administration of 100 microcuries of carrier-free radioiodine a specimen of blood is obtained. The serum is analyzed for total radioactive iodine and for radioactive iodine in the thyroxin form. The analysis is performed by first treating the serum with an alkaline reagent and then extracting the thyroxin with normal butanol.

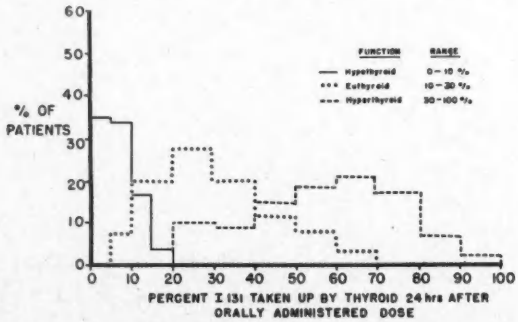

Chart 2.—Distribution of values for 24-hour thyroid gland uptake of radioactive iodine in 500 studies of patients with varying states of thyroid activity. Overlap is similar to that for protein-bound iodine.

The butanol extract is then washed with an alkaline reagent, which leaves the radioactive thyroxin in the alcohol layer. Only a 2 cc. sample of serum is necessary for the analysis. (Details will be published elsewhere.) As with other diagnostic techniques using radioiodine, previous intake of iodine-containing drugs can alter results.

The results in 500 studies of patients in the Veterans Administration Hospitals in Van Nuys and Long Beach are shown in Chart 3. Values in euthyroid persons range from 2 to 10 per cent; in most hyperthyroid persons the value is between 50 and 70 per cent; in nearly 95 per cent of hypothyroid persons it is less than 1 per cent, and the overlap between values found in euthyroid persons and those of patients with thyroid dysfunction is slight in comparison with the normal range. The diagnosis in all cases was based upon ultimate clinical outcome including therapeutic response in those with dysfunction. Each patient was first examined on the medical service, then referred to the metabolic ward of the radioisotope unit. After repeat examination, laboratory studies of thyroxin synthesis, of thyroid uptake and urinary excretion of radioiodine, of protein-bound iodine, and of blood cholesterol were made and the basal metabolic rate measured three times.

The sensitivity of the thyroxin synthesis test in indicating hypothyroidism and hyperthyroidism may be attributed, in part, to the fact that the turnover of circulating thyroxin rather than of a mixture of protein-bound iodine compounds is being measured. Chart 4 shows that the turnover of radioactive thyroxin differs from that of the non-thyroxin moiety of the radioactive protein-bound iodine,

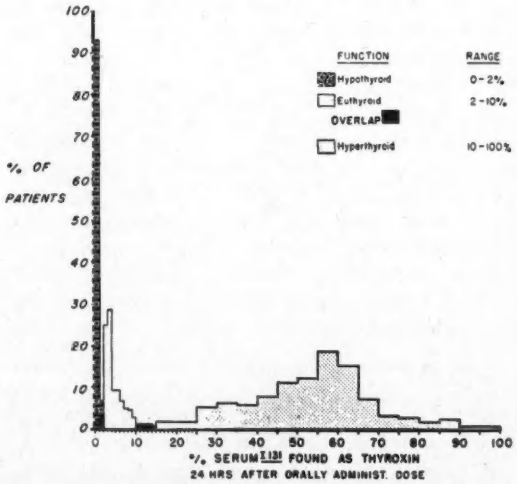

Chart 3.—Distribution of radiothyroxin synthesis values as found in 500 studies. There is relatively little overlap between different states of thyroid function.

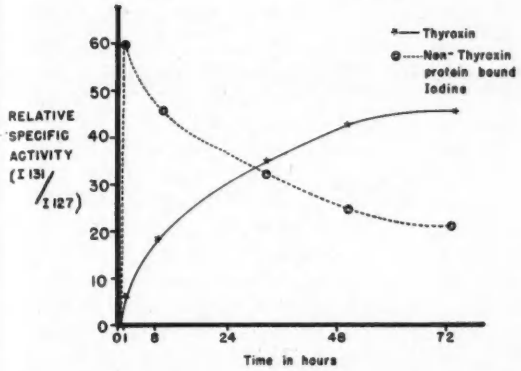

Chart 4.—The newly formed thyroxin, as measured with radioactive iodine, is shown to be different from the other organic iodine compounds in the protein-bound iodine of the serum in terms of its slower turnover rate.

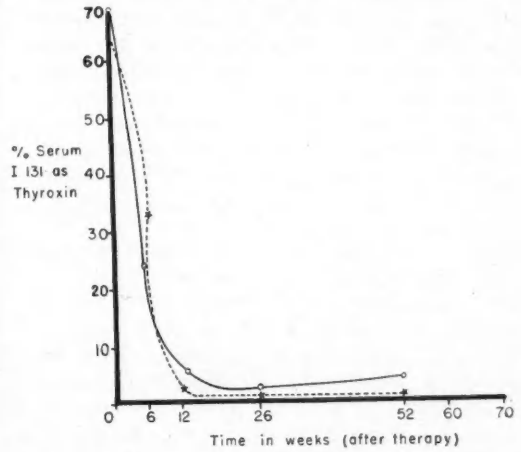

Chart 5.—Results of thyroxin synthesis determinations for two patients who received radioiodine for hyperthyroidism. The course of the patient traced by the solid line resulted in a euthyroid condition; that with the broken line depicts resultant hypothyroidism.

which appears to have a more rapid turnover than thyroxin.

Chart 5 shows thyroxin synthesis values in a patient treated with radioiodine for hyperthyroidism. Twenty-four hours after a test dose of I^{131}, 70 per cent of the radioiodine in the serum was in the form of thyroxin. On repeat test at the time of therapy a value of 69 per cent was obtained. Six weeks after the therapeutic dose the value was 24 per cent, indicating a definite therapeutic effect. At three months it was 6 per cent, and at six months 3 per cent. On follow-up one year after therapy a value of 4 per cent was obtained, still well within the euthyroid range. These results illustrate not only the separation between values found in hyperthyroidism and euthyroidism but also the constancy of the test as a measure of thyroid function and its usefulness in

TABLE 1.—*Induction of Thyroxin Synthesis in Thyroid Carcinoma Metastases and Response to Radioiodine Therapy*

Time (months)	Cumulative I^{131} (mC)	24-Hour Thyroxin Synthesis (%)
0	0*	3.5
2	37	10.0
4	106	14.0
10	296	1.5
12	452	0.6
16	552	0.2

* One week before total thyroidectomy and radical neck dissection.

following the results of therapy. By testing at proper intervals the need for additional therapy can be anticipated and thus considerable time may be saved in restoring the patient to a euthyroid condition. The sensitivity of the test in distinguishing hypothyroidism from euthyroidism is also shown in Chart 5.

In another patient with hyperthyroidism treated with I^{131}, the thyroxin synthesis value was 63 per cent before treatment. Six weeks after therapy it was 32 per cent; after three months, 2 per cent; after six months, 0.4 per cent, and after one year, 0.5 per cent. At the end of a year the patient had symptoms and signs of myxedema, which responded to treatment with desiccated thyroid.

In Table 1 are shown results demonstrating the sensitivity of the thyroxin synthesis test in detecting functioning metastases of thyroid carcinoma following total thyroidectomy, radical neck dissection and repeated doses of radioactive iodine. The metastases were so small that they could not be delineated by scanning techniques. The intermediate rise in thyroxin synthesis values was attributed to thyrotropic hormone stimulation of the metastases.

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Rheumatic Fever and Rheumatic Heart Disease

Incidence in California

ALFRED F. GOGGIO, M.D., *Berkeley*

• *The statistics quoted in this and other published reports appear to substantiate the impression that rheumatic fever in California, although still an important public health problem which varies widely from one locality to another, is of lower incidence and perhaps of more benign character than in most other parts of the United States. It also appears that in California aortic insufficiency may be of higher relative incidence and occurs more frequently as a clinically diagnosable sequel of rheumatic fever than does classical mitral stenosis. Congenital defects of the heart constitute a large proportion of the cases of organic heart disease in children and young adults in this state.*

THE INCIDENCE AND IMPORTANCE of rheumatic fever and rheumatic heart disease in California are a matter of some controversy. Many observers contend that the incidence is very low, while others attribute the apparently low incidence to failure to diagnose the disease or to the benign character of it as it occurs in this state.

Richter[6] in 1931 reported a study of heart disease in San Francisco school children in which she found the incidence of rheumatic heart disease about equal to the incidence of congenital heart disease. As there was no reason to expect a higher incidence of congenital heart disease here than elsewhere, it was concluded that the incidence of rheumatic heart disease must be low. Christie[1] in 1936 reported similarly that in children of school and preschool age with organic heart disease studied at the cardiac center of the San Francisco Department of Public Health, almost 50 per cent of cases were congenital in origin. His observations on patients admitted to the pediatric wards of the San Francisco and University of California hospitals, however, led him to conclude that the incidence of rheumatic fever was about the same as in other parts of the country, while the incidence of resultant heart damage was considerably less. He concluded therefore that the rheumatic process was relatively benign.

The incidence of rheumatic heart disease in children of school and preschool age in San Francisco and environs has been found by Sampson and co-workers[8] to be 2.2 per thousand and Robinson and co-workers[7] to be 2.43 per thousand—both relatively low figures. Davis and Rosin,[2] studying records of children admitted to Los Angeles hospitals, found the incidence of rheumatic fever lower than in most parts of the country but "consistent with that found in other subtropical areas." A survey of the school children of five counties conducted in 1947 yielded reports of 572 cases of rheumatic fever among 108,000 children, an incidence of approximately 5 per thousand (the detail of the method and the reliability of this study are not known to the author). That there can be extreme variation in incidence between one locality and another is well illustrated by the report of Sampson and co-workers[9] on the incidence of heart disease and rheumatic fever in school children in three climatically different California counties. They found an incidence of rheumatic heart diseases and rheumatic fever as high as 20.4 per thousand in Eureka, as compared with 3.2 per thousand in Redlands—the latter figure much more in keeping with reported incidence in other areas of California. Morbidity and mortality statistics from public health records,[10] crude though they may be, support belief that the over-all incidence in this state is low. Death from heart disease between the ages of five and nineteen years occurs in California at the rate of 6.3 per hundred thousand, the second lowest for any state.

It is in the young adult population that rheumatic and congenital heart disease is of greatest interest and importance, and it is in this group, apparently, that the least information is available. An opportunity was found in the medical examination of all newly registering students at the University of California, Berkeley campus, to study the incidence of heart diseases, rheumatic and congenital, in a young adult population and at the same time to form an impression of the relative incidence of these diseases in the state of California as based entirely on the stated place of birth of each student.

Each student registering at the university for the first time is required to enter certain biographical and medical data on a dispensary record card and is given a physical examination which includes an

Presented before the Section on General Medicine at the 81st Annual Meeting of the California Medical Association, April 27 to 30, 1952, Los Angeles.

x-ray film of the chest. If the history is suggestive of rheumatic fever or heart disease, if any heart murmur or cardiac or cardiovascular abnormality is noted in physical examination, or if any abnormality is observed in the cardiac silhouette on the x-ray film, the student is examined further by a cardiologist. Careful history-taking, clinical and fluoroscopic examination and electrocardiographic readings are used for diagnosis. The Criteria for Diagnosis of Diseases of the Heart[5] adopted by the American Heart Association are strictly applied.

The findings of the survey, which included all students entering the university for the first time in the fall semesters of 1949 and 1950, are given in Table 1. About half the students examined were native Californians, yet only 23.3 per cent of all students who had rheumatic heart disease were born in the state. Despite the relatively small number of cases upon which this study is based it appears, according to statistical probability tables, to be quite reliable. Among all students born in California, the incidence of rheumatic heart disease was only 1.24 per thousand, a remarkably low figure which differs very little from the observed incidence of congenital heart disease in California.

Are these figures for rheumatic heart disease credible? Studies made in other colleges and universities, for the most part by reviewing records of the past rather than by prearranged surveys, indicate in general a considerably higher incidence than that for California. For example, Hedley[6] found the average incidence of rheumatic heart disease among students at fourteen colleges and universities situated in various parts of the United States to be 6.4 per thousand. On the other hand, if the statement by T. Duckett Jones is to be relied upon, that only 40 per cent of children who have had rheumatic fever have clinically demonstrable heart disease upon reaching college age, then the incidence of 1.24 per thousand for rheumatic heart disease for California natives seems quite in line with the figures cited above on the incidence of rheumatic heart disease among California children of school age and younger. It is to be noted, of course, that the screening method and the strict criteria applied in this study make the figure a minimum one.

Another interesting observation was made in the course of this study: Aortic insufficiency was diagnosed in almost 50 per cent of all the cases of proven rheumatic heart disease. It was observed that in this survey, as in examination of students at the University of California generally, aortic diastolic murmur was more often noted than the presystolic and diastolic murmurs associated with mitral stenosis. This observation agrees closely with that of Levy, Stroud and White[4] on the reexamination by cardiovascular specialists of 4,994 men from four major cities in the United States who were disqualified for general military service. In this reexamination it was found that the men from San Francisco, where there is a relatively low incidence of rheumatic heart disease, had a higher incidence of aortic insufficiency than of any other valvular lesion—a finding quite different from that in the three other cities.

TABLE 1.—*Incidence of Heart Disease in Students Registering at University of California, 1949-1950*

	Totals for 1949 and 1950		
	Number	Per cent	Per cent born in California
Total registering students	11,096	100.00	50.9*
Referred for cardiac study	378	3.41	
Chronic rheumatic heart disease	30	0.27	23.3
Mitral valve involved	20		
Aortic valve involved	14		
Mitral and aortic valves involved	5		
Congenital heart disease	12	0.11	58.3
Total proven heart disease	42	0.38	
Possible heart disease	26	0.23	50.0
Physiologic murmurs	291	2.62	55.3
Other (arrhythmias, etc.)	19		

* Estimated from a random sample obtained by noting birthplace of every fortieth registrant in the order in which they reported for processing at the Student Health Service.

2490 Channing Way.

ACKNOWLEDGEMENT

The author acknowledges with thanks the generous cooperation received from William G. Donald, M.D., physician to the University of California, and from Miss Glenn Gibson, R.R.N., and Miss Jeanette Wheeler of the administrative staff of the Ernest V. Cowell Memorial Hospital, in the accomplishment of this study.

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Primary Pulmonary Resection for Tuberculosis

Medical and Economic Aspects in a Small Sanatorium

LOUIS M. BARBER, M.D., *Murphys*, and PAUL C. SAMSON, M.D., and DAVID DUGAN, M.D., *Oakland*

• Twenty-eight patients with pulmonary tuberculosis in a small, tax-supported sanatorium were treated by primary pulmonary resection. In a comparison of results with those obtained in the same sanatorium by thoracoplasty and extrapleural pneumothorax, it was noted that in general the patients who had resection had earlier conversion of sputum to "negative" and had a shorter stay in hospital.

Complications were not of sufficient frequency to contraindicate use of resection in cases in which there was doubt that thoracoplasty would be effective.

The cost of hospitalization for surgical treatment and postoperative care was considerably less when resection was done than it was for either three-stage or two-stage thoracoplasty.

IN THE PAST THREE YEARS pulmonary resection has been used in an increasing proportion of cases at Bret Harte Sanatorium, a 230-bed hospital operated by San Joaquin County for tuberculous patients. Since the acceleration of the program, data have developed that permit comparison of results of resection with those obtained in the same hospital by thoracoplasty and by extrapleural pneumothorax. Also some light is cast on medicoeconomic factors with regard to the three methods.

Data on the length of time between treatment and the disappearance of tubercle bacilli from the sputum—"conversion"—are given in Table 1. It is noteworthy that 75 per cent of the patients subjected to resection had conversion within two months, whereas in the thoracoplasty group only 15.3 per cent had conversion in that length of time. (Not included in the table are the nine cases in which resection was done most recently. In all of them conversion occurred within two months, making 31 two-month conversions in a total of 37 patients who had resection.) Results obtained with extrapleural pneumothorax cannot be equitably compared with results in patients treated by thoracoplasty, of course, for pneumothorax was used for patients in whom the conversion rate would have been relatively high whatever the method of treatment.

It is still too early to gauge the long-term results of resection or to say what the future of the program will be. It is perhaps indicative, however, that 23.3 per cent of patients who had thoracoplasty and 10 per cent of those treated by extrapleural pneumothorax did not have conversion of sputum to "negative," whereas all living patients in whom resection was done had conversion before they left the sanatorium.

TABLE 1.—*Sputum Conversion Rates Concomitant with Various Methods of Treatment*

Conversion Months Postoperatively	Thoracoplasty (124 cases)	Extrapleural Pneumothorax (76 cases)	Pulmonary Resection (28 cases)
0-2	15.3*	30.0*	75.0*
2-4	11.5	12.0	4.2
4-6	8.6	26.0	4.2
Total within 6 months	34.4	68.0	83.4
Over 6 months	42.3	22.0	8.2
Not converted	23.3	10.0	8.2

*Expressed in per cent of cases in which sputum converted to negative from positive in stated period.

Charts 1 and 2 show the number of operative procedures in each of the three categories and the relative frequency of use of each method. Decreases in thoracoplastic and extrapleural procedures since 1949 have been more than compensated for by an increase in resections. Since thoracoplasty is done in stages whereas resection takes but one operation, the total number of operations has decreased. Also in the last two years thoracoplasty has been done more often in two stages rather than three as previously (without change, however, as to the number of ribs removed).

In recent years a higher proportion of patients admitted have been treated surgically (Table 2). There are two reasons for this. One is that the three surgeons who carry out the procedures have been operating four times a month since 1950, as against twice monthly theretofore. The other is that during the last three or four years there has been a gradual increase in the number of patients who, because of chronic alcoholism or mental instability, are not

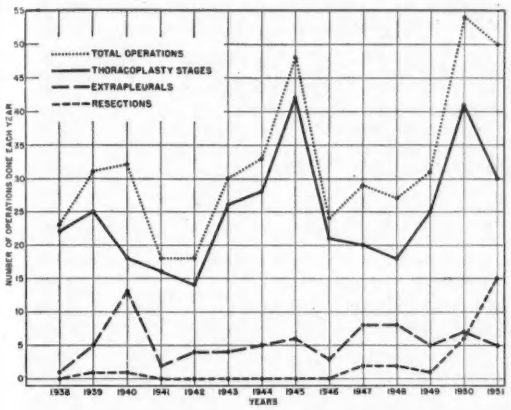

Chart 1.—Total number of operations and the numbers of each kind in period 1938-1951 inclusive.

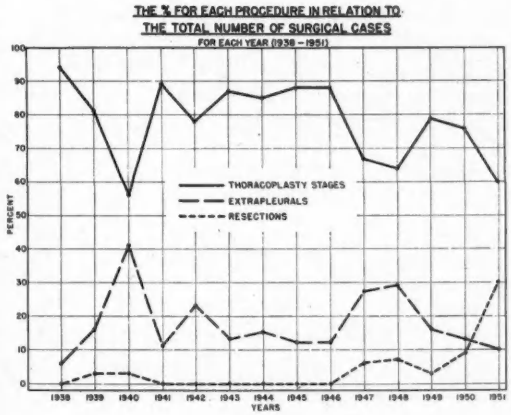

Chart 2

suitable candidates for a regimen based upon a reversible collapse procedure, which necessitates cooperation on their part.

The question of how long a patient is to stay in the sanatorium is difficult to answer, since in most institutions the availability of beds is a strong factor. At Bret Harte the preoperative care of patients who are to have resection is the same as that in most institutions, but postoperative care is somewhat different. Patients are advised before resection that no matter what the results of the operation, they will have to remain in bed for six months postoperatively. The reason for this is that, in the operation, attempt is made to preserve all but that portion of the lung which cannot be collapsed by surgical or other means. If at the time of operation a few nodules are felt in the remaining lobes, the surgeons leave them unless there is cavitation. In no case have there been complications attributable to rest in bed postoperatively. In a few instances patients who felt well could not be made to stay in bed for the prescribed period.

TABLE 2.—*Number of Patients Operated Upon in Relation to Number Admitted During Year*

Year	Proportion Operated Upon (per cent)	Year	Proportion Operated Upon (per cent)
1938	15	1945	30
1939	19	1946	14.7
1940	19.3	1947	15.6
1941	12	1948	13.6
1942	12.4	1949	16
1943	18.7	1950	24.5
1944	20	1951	22.2

Postoperative chemotherapy as practiced at Bret Harte may differ from that in many institutions in that patients are given streptomycin intermittently and para-aminosalicylic acid daily for three months. The average length of stay in the sanatorium following resection was 11 months, as against 12 months after extrapleural pneumothorax, and 15 months after thoracoplasty. It is recognized, however, that the resection series is so small (28 cases) that definite conclusions are not warranted.

COMPARISON OF COSTS

Valid comparison of the costs of the various kinds of operation can be made, however, if it be assumed that in a given case either thoracoplasty or resection could be used. Patients at Bret Harte Sanatorium must be transported 75 miles to a general hospital for any major operation, and the hospital charges the county a set rate daily, based upon the cost of caring for patients undergoing operation at that institution. The average bill to the county for patients who had resection was $340, against $800 for three-stage and $512 for two-stage thoracoplasty. For extrapleural pneumothorax the cost was $258. The comparison of costs, it should be noted, came after the fact; the differences in cost were not a factor in choice between procedures. The staff is keenly interested, however, in avoiding trial thoracoplasty for a patient who would be better served by resection. Of 37 resections done up to the time of this report, only three were in cases in which thoracoplasty had been done earlier—before 1944 in two instances. One was in a case in which extrapleural pneumothorax had failed.

The indications for resection in the group of 37 patients were as follows: Bronchostenosis, totally destroyed lung, giant cavities, bronchiectasis, lower lobe cavities, nonexpansile lung with cavitation still present, cavitation which might not have closed with thoracoplasty, failure of thoracoplasty, and failure of extrapleural pneumothorax. Of the 37 patients, ten had upper lobe lobectomy with concomitant thoracoplasty. In three cases in which pneumonec-

tomy was done, the remaining pleural space was filled with air, and refilling was done from time to time for periods up to two years with no complications. In two other cases, the pleural space was allowed to fill with serum and no postoperative thoracoplasty was done. In two cases concomitant thoracoplasty was carried out.

COMPLICATIONS

Complications following resection were not such as to change the authors' belief that upper lobe lobectomy, with concomitant thoracoplasty, is to be preferred in suitable cases over thoracoplasty alone. Nor was the factor of complications of sufficient weight, all things considered, to gainsay primary resection in cases in which thoracoplasty might not be effective. The complications that occurred in the first 28 resections done are listed in Table 3. (No complications occurred in the next nine resections.) Bronchopleural fistula occurred in four cases—in two instances before the advent of streptomycin. Two of the four patients in whom fistula developed died (one in the prestreptomycin era and one after the drug became available); the other two are alive and well with the fistula closed. In the two cases in which contralateral spread occurred, the patients had left the sanatorium against medical advice within three and a half to four months postoperatively. Both were back within three months after leaving, and one of them died. The four patients in whom fistula developed and the three who died had had pneumonectomy. Taking two months postoperatively as a time limit, there were no postoperative deaths in the resection or extrapleural group, five in the thoracoplasty group.

TABLE 3.—*Complications Associated with Surgical Procedures*

	Thoracoplasty (124 cases)	Extrapleural Pneumothorax (76 cases)	Resection (28 cases)
Wound infection	14	0	1
Contralateral spread	6	4	2
Ipsilateral spread	2	1	0
Respiratory disability, dyspnea	2	0	0
Bronchopleural fistula	0	0	4
Rapid reexpansion	0	1	0
Postoperative death (within 60 days)	5	0	0

Bret Harte Sanatorium, Murphys.

Primary Carcinoma of the Duodenum

HAROLD P. TOMPKINS, M.D., Los Angeles

• *As the only hope for patients with malignant disease of the duodenum depends upon early diagnosis and prompt and adequate operation, suspicion must be alert even though the condition is relatively rare. The incidence is highest in persons between 50 and 70 years of age, and two or three times as high in males as in females.*

The onset is insidious. The patient usually gives a history of fairly good health and no other related symptoms until about a year before diagnosis. Early symptoms are loss of appetite, loss of weight, and moderate pain in the right upper quadrant of the abdomen, sometimes associated with epigastric fullness which is relieved by belching. Vomiting and constipation are late symptoms. There may be occult blood in the stools, moderate anemia in some cases, and frequently jaundice.

The radiological findings are irregularity of the mucosal pattern in the region of the tumor and often constriction of the involved portion of duodenum.

A report is made herein upon four cases of primary carcinoma of the duodenum observed at one hospital in a period of only a little more than two years.

ALTHOUGH TUMORS of the small bowel are relatively rare and therefore not of uppermost interest statistically, that they do occur must be kept in mind, for the only hope for a patient with malignant disease of the duodenum lies in early diagnosis and prompt, adequate excision. Bennett[1] recently reported upon three patients who lived more than ten years after removal of carcinoma at that site.

Numerous studies of autopsy series have been made to determine the incidence of primary duodenal carcinoma. Hoffman and Pack,[2] in a review of 350,286 autopsy reports, noted that the incidence was 33 per 100,000 (0.033 per cent), and other reports are in close agreement.

As such tumors are rare and they develop insidiously, preoperative roentgen diagnosis is made in only about 25 per cent of cases—and no other method of diagnosis approaches even that degree of accuracy.

The lesion can occur at almost any age, but the incidence is highest in persons between 50 and 70 years of age. The disease affects two or three times as many males as females.

The tumors may originate in any portion of the duodenum. Approximately 22 per cent occur in the suprapapillary portion—the area above the common duct opening which is divided embryonically from the foregut. Some 60 per cent originate in the peripapillary region, where the tumor may rise from the ampulla of Vater, from the duodenum proper, from the pancreatic duct, or from the terminal portion of the common bile duct. The variety of tissue sources probably accounts for the preponderance of tumors there. About 18 per cent grow from the infrapapillary portion.

In most cases of this insidiously developing tumor, the patient has a history of fairly good health with no symptoms related to the gastrointestinal tract until about a year before diagnosis. Anorexia and loss of weight may be noticed for three to six months. Pain in the right upper quadrant of the abdomen may be a complaint, and the pain may be followed by or associated with epigastric fullness which is relieved by belching. Constipation may be a late symptom.

Chairman's address: Presented before the Section on Radiology at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

Often noted are moderate anemia and occult blood in the stool. Gross melena has been reported, but it is not usual. Jaundice and, all too frequently, a palpable mass may be noted upon physical examination.

Histologically, the lesions usually are carcinomatous. Annular constricting lesions appear to be more frequent in the first and second portions of the duodenum, while large fungating, ulcerating and polypoid lesions are more often found in the third portion. Involvement of the ampulla of Vater is not common. Lesions of the second portion, of course, most often cause jaundice.

Metastases, although they occur relatively late, are found in approximately 30 per cent of all cases. The spread is first to regional nodes, then to the liver, lungs and bones.

Etiological factors are to a large degree speculative. There appears to be some controversy as to

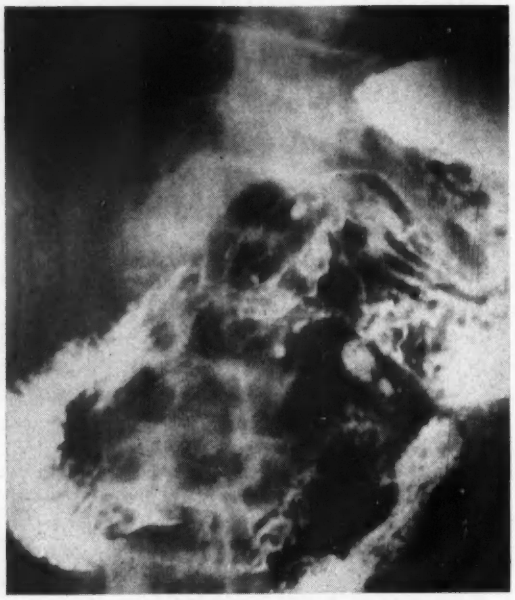

Figure 1 (Case 1).—Apparent filling defect in third portion of duodenum.

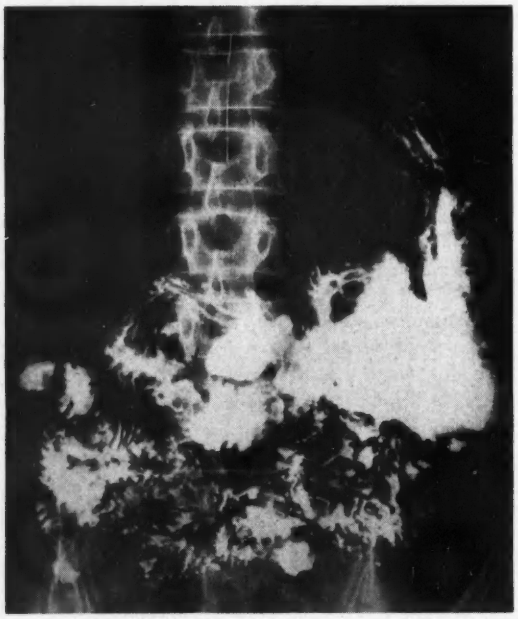

Figure 2 (Case 2).—Apparent ulcerating defect at junction of second and third portions of the duodenum.

No masses were palpated in the abdomen. Erythrocytes numbered 4,000,000 per cu. mm. of blood and the hemoglobin content was 15 gm. per 100 cc. In roentgen studies of the gastrointestinal tract an old duodenal ulcer and a lesion in the third portion of the duodenum were observed (Figure 2).

whether carcinoma of the duodenum can arise from chronic ulceration of the bulb, but the preponderance of opinion seems to be that that is not a factor. The presence of impacted gallstones has been thought to account for the lesion in some cases. Abrupt changes in the chemical composition of the secretions that bathe the duodenal mucosa may play a small part.

Radiographically observable abnormalities associated with duodenal tumors are irregularity in the mucosal pattern in the region of the lesion, narrowing of the lumen in the case of constrictive lesions, and filling defects within the lumen caused by polypoid or bulky lesions. Various degrees of constriction of the duodenum cause corresponding dilation of the duodenum proximal to the lesion. Even the stomach may be dilated if the obstruction is severe.

Following are reports of four cases of proven primary carcinoma of the duodenum observed at the Queen of Angels Hospital between May 1949 and July 1951.

CASE 1: A 75-year-old white man was admitted to the hospital May 15, 1949, with the complaint of obstipation. Constipation had developed gradually over the preceding three or four years, but rectal operation of minor nature had largely relieved the condition until two months before admittance.

The patient was well developed, but poorly nourished. He was mentally alert, but appeared to be ill. The abdomen was soft. In a sigmoidoscopic examination no significant pathologic change was noted. The colon appeared to be normal roentgenographically also. In films of the upper gastrointestinal tract, a widened duodenal loop with a partially obstructing lesion of the third portion were noted (Figure 1). The appearance of the small bowel was that associated with a deficiency state. Erythrocytes numbered 3,277,000 per cu. mm. of blood and the hemoglobin content was 10.7 gm. per 100 cc.

Upon exploratory laparotomy an iliac mass of retroperitoneal nodes was observed. The small bowel, liver, stomach, gallbladder, spleen and kidneys were examined by the surgeon and were considered normal. A specimen was excised from the retroperitoneal nodes, and the pathologist reported "adenocarcinoma, metastatic."

Autopsy was done August 15, 1949. The stomach was dilated. In the third portion of the duodenum, distal to the ampulla and not connected with it, was an ulcer 3 cm. in diameter.

The final diagnosis was ulcerative adenocarcinoma of the duodenum with retroperitoneal lymph node metastases, adrenal metastases and metastatic nodules in the ileum and jejunum.

CASE 2: A 58-year-old white male physician was admitted to the hospital January 21, 1951. The patient, a member of the hospital staff, had complained of progressive loss of weight over the preceding two years. He had had a duodenal ulcer, with symptoms, since 1936. For six months before admittance the patient vomited late after meals and had a constant feeling of distention, but very little pain. There was no history of gastrointestinal bleeding or of any symptoms referable to the bowel. The patient complained of considerable nausea and anorexia with progressive weakness and exhaustion. There was no history of jaundice.

On January 24, 1951, a Whipple-type resection was done. A duodenal ulcer was observed, and separate and distinct from it was a mass in the third portion of the duodenum with involvement of the adjacent lymph nodes. The pathologist who examined the material diagnosed duodenal ulcer and primary adenocarcinoma of the third portion of the duodenum with regional lymph node metastases.

The patient did not recover well, and although he was able to leave the hospital he died within a few months.

CASE 3: A 35-year-old white policeman was admitted to the hospital June 21, 1951, with complaint of chills and fever with gastric discomfort. Six weeks before admittance the patient had had chills and fever for about three days and then had gone back to work. Several similar attacks occurred. The night before admittance, chills and fever recurred—this time with vomiting. The vomitus was dark brown. The patient had no appetite and noted a feeling of fatigue and general weakness.

Upon physical examination slight icterus of the sclera was noted. There was no abdominal tenderness, the liver was not palpable and the spleen did not seem to be enlarged. The diagnosis was infectious hepatitis.

Results of agglutination tests were negative for typhoid, paratyphoid and brucella. Erythrocytes numbered 3,100,000 per cu. mm. of blood and the hemoglobin content was 9 gm. per 100 cc. In a survey film of the abdomen made August 30, 1951, there was indication of gas in the colon with some air-filled and partially distended loops of small bowel in the right lower and right central portions of the abdomen. In gastrointestinal roentgen study made elsewhere before the patient was admitted to the hospital, there was no evidence of any lesion of the upper gastrointestinal tract.

A diagnosis of cancer of the head of the pancreas was made and operation of the Whipple type was carried out. An ulcerative tumor mass which lay 8.5 cm. distal to the pylorus protruded into the lumen of the duodenum and encircled the ampulla of Vater. The pancreas was not involved. The pathologist's diagnosis was obstructive adenocarcinoma at the ampulla of Vater with extensive lymphatic herniation and regional lymph node metastases.

The patient recovered from the operation sufficiently to go home in fairly good general condition but was later reported to have entered a Veterans Administration hospital. His condition then was considered hopeless and he died October 15, 1951.

CASE 4: A 52-year-old white woman was admitted to the hospital July 16, 1951, with complaint of a mass in the epigastrium which had been noticed for the previous six or eight weeks. There had been epigastric discomfort with considerable distention after meals for approximately two months before admittance. The patient had found that massaging the gastric area gave some relief, and in massaging had felt the mass, which was moderately tender. There was no history of jaundice or of previous gastric disturbance. The body weight had decreased approximately five pounds since the onset of symptoms.

The patient's father died of carcinoma of the stomach.

The hemoglobin content of the blood at the time of admittance was 13.4 gm. per 100 cc. In roentgen study of the upper gastrointestinal tract, a large mass displacing the lesser curvature and the distal portion of the duodenum was observed (Figure 3).

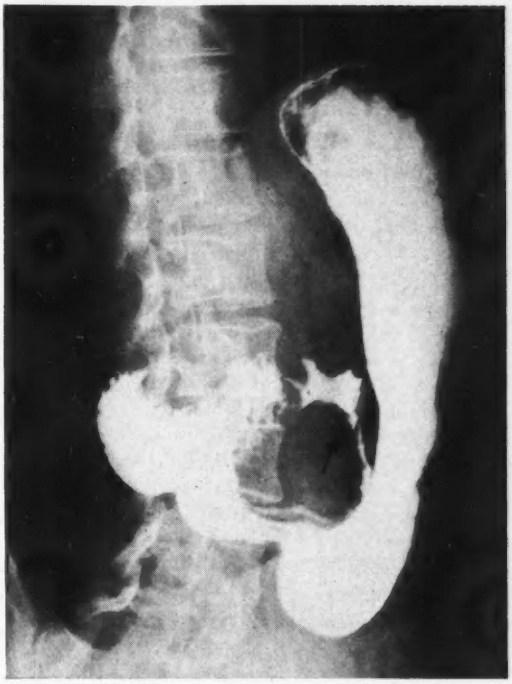

Figure 3 (Case 4).—Mass displacing lesser curvature of stomach and causing distortion of distal portion of duodenum and adjacent jejunum.

On July 17, the duodenum and 14 cm. of the jejunum were resected and anastomoses of the jejunum with the pyloric end of the stomach was carried out. The common bile duct and the duct of Santorini were transplanted. The pathologist's diagnosis was ulcerative mass at the ligament of Treitz. The mass encircled the distal end of the duodenum, and there was enlargement of lymph nodes in the area. Upon histologic examination the mass was observed to be adenocarcinoma of the fourth portion of the duodenum, with extensive regional lymph node metastases. The patient died September 4, 1951.

658 South Westlake Avenue.

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One-Stage Bilateral Radical Neck Dissection

Indications and Technique

S. L. PERZIK, M.D., Beverly Hills

• *Simultaneous bilateral radical neck dissection is an operation entailing acceptable risk if used in properly selected cases. The procedure is indicated for patients with bilateral cervical lymph node metastases so situated that a two-stage radical neck dissection could not be done without cutting through cancer tissue. Such patients are those with intraoral or cervical visceral midline primary lesions or those in whom, either by direct extension or lymph node involvement, the submental and submaxillary triangles are solidly permeated with cancer. The operation is indicated only for cure; for prophylaxis or palliation, lesser or staged procedures would be more productive of better results with less morbidity and mortality.*

BLOCK DISSECTION of regional lymph node areas for metastases is a fundamental procedure in the management of cancer. In no area of the body is such an operation productive of more satisfactory results than in the neck. There are several reasons for this. First, almost invariably when patients die of cancer of the head and neck death is caused by the local effects of the disease rather than by distant metastases. Therefore, the more complete the local operation on head and neck, the better the end-results. Disease in this area is more amenable to early detection and appraisal. Although primary cancer in the mucosal surfaces of the head and neck frequently spreads to the regional cervical lymph nodes, the disease, nevertheless, will remain localized above the clavicle for months or even years. Hence there is a long, safe period of attack for eradication. Finally, and most important, a more complete removal of the regional node-bearing area "en masse" is possible in the neck than in any of the other node-bearing areas of the body. This is because the main lymphatic channels and lymph nodes accompany the major veins of the area involved.

If the nodes are involved with cancer, not infrequently the afferent and efferent channels are permeated with the disease and to a lesser or greater degree they are adherent to the associated vein. Many a surgeon, in attempting to save these vessels, has experienced the frustration of scraping or sharply dissecting these adherent nodes from the vein.

In the neck the internal jugular vein is relatively long and occupies the major pathway of the cervical lymphatics. Since this vein is excised from the level of the clavicle to well above the posterior belly of the digastric muscle in a radical neck dissection, and since the sternocleidomastoid muscle is also taken, it is possible to remove as a block of tissue practically all the lymph node-bearing area lying between the superficial fascia and the second layer of the deep cervical fascia. The first or enveloping layer of the deep fascia contains this mass of tissue and if the sternocleidomastoid muscle as well as the internal jugular vein is excised, this space need not be entered except at the periphery of the dissection. In fact, during such a dissection the lymph nodes can frequently be palpated through the protecting layers of the surrounding fascia, but are usually never seen or individually exposed.

If a similar sacrifice of accompanying vein were possible in other node-bearing areas, such as the axillae, groins, iliac and aortic areas, the technical accomplishment of a "clean" and complete dissection in these regions could be attained. With the questionable exception of the axilla in some cases, this ideal situation has not been approached except in the neck.

A second fundamental principle in the surgical treatment of cancer is to avoid cutting through cancer tissue during its removal. In the past when both sides of the neck were involved with metastatic spread of cancer, a staged bilateral neck dissection was the accepted treatment, if cure were still possible. If the cancer in the neck intimately involved the anterior midline tissues (as is often the case), the surgeon carrying out this treatment either had to cut through cancer tissue in dividing the neck tissues for a staged bilateral neck dissection or limit the combined neck dissection on one side to a suprahyoid, supra-omohyoid or local excision of involved lymph nodes. He might even decide to do a bilateral suprahyoid neck dissection.

Presented before the Section on General Surgery at the 81st Annual Session of the California Medical Association at Los Angeles, April 27 to 30, 1952.

All of those procedures are incomplete and dangerous, for they immediately jeopardize the patient's chances of ever receiving the benefit of a safe and complete block dissection of the neck, should there be recurrence. Such limited procedures in the neck terminate in the carotid triangle, and if lymphatic channels containing carcinoma are cut through at that point the recurrent growth will spread into the surgically opened field, through the destroyed protective fascial barriers, and become adherent to the carotid bulb and surrounding muscular floor of the neck. Such a recurrent situation is technically incurable by operation. Even if there is only a very small recurrent lesion adherent to the carotid bulb which can be removed by excising the bulb, the mortality rate associated with the operation is almost 60 per cent—and the chance of cure is less than it is with radical neck dissection which entails operative mortality of only 1 per cent.

To satisfy these fundamental principles of block dissection of a primary cancer and its immediate lymphatic drainage basin in certain midline lesions of the neck, it was necessary to extend the surgical management to include simultaneous bilateral radical neck dissection. Originally it was felt that the anatomical and physiological disruptions entailed in an operation of this magnitude were so great that it would almost certainly be fatal. No reports of an operation of this kind could be found in the medical literature. There were frequent references to simultaneous bilateral internal jugular vein ligation[1] and a few reports of excision of several centimeters of both internal jugular veins,[2, 3] but such limited venous excisions and ligations are not comparable to the contemplated procedure.

The term radical or block dissection of the neck requires some definition. In this presentation it refers to the removal of all the venous and lymphatic systems between the superficial and third layer of the deep fascia of the anterior and posterior triangles of the neck, including the sternocleidomastoid and omohyoid muscles, as well as all or any part of the midline cervical viscera, if involved.

The feasibility of a staged bilateral radical neck dissection with an interval of one to three weeks has been adequately demonstrated.[4] It was presumed, however, that the simultaneous excision of the internal, external and anterior jugular veins with the connecting collateral tributaries and the encompassed lymphatic system from the mandible down to the clavicle would be incompatible with survival. Therefore, the operation was not only never seriously considered but the thought of it was even frowned upon. The literature contains many references[5, 6, 7] to the impossibility of simultaneously eradicating so much of the cervical venous system, and despite current demonstration to the contrary, there are still frequent references to the hazard of removing both internal jugular veins in a two-stage block dissection of the neck. It can be well understood, therefore, why the consummation of this operation was so long delayed. The first successful result in simultaneous bilateral radical neck dissection was not attained until June, 1949.[8]

COLLATERAL CIRCULATION

Recovery after an operation of this scope is dependent primarily upon the potential capacity of the remaining venous channels to drain the cranial cavity and the dural sinuses. The vertebral veins of Batson[9-13] form the safeguard of this collateral return. This system of veins passes as a plexiform network, primarily in a vertical direction, both intraspinally between the dura and vertebrae and extraspinally between the vertebrae and the erector spinae group of muscles.

By way of the foramen magnum, this system communicates with the occipital and basilar sinuses which connect with the major intracranial dural sinuses. Numerous basal skull emissary veins empty into this system through collateral tributaries. At all vertebral levels these vertical veins anastomose transversely with each other and with the intercostal and lumbar veins which connect, either directly or by way of the azygos system, with the caval venous system. This vertebral azygos-caval route provides a detour of venous return from the brain and cranial cavity to the right side of the heart. Usually the vertebral system of veins is constantly functioning and, owing to absence of valves and low venous pressure, the blood may travel in either direction.

Under abnormal conditions of obstruction to the superior caval veins, the carrying capacity of the vertebral system increases, as has been clinically demonstrated. Since both anterior facial veins are also ligated in this operation, the intracranial return of venous blood from the cavernous sinus and ophthalmic vein is blocked. In addition, the pterygoid and pharyngeal plexus, the superior and middle thyroid veins, the transverse cervical veins and the common facial veins with their posterior facial and occipital anastomoses are cut off from drainage into the jugular system. After operation, therefore, the only superior caval veins assisting the vertebral system are the inferior thyroid, deep cervical and vertebral tributaries of the subclavian and innominate veins and the transverse scapular veins by way of the shoulder and posterior neck regions.

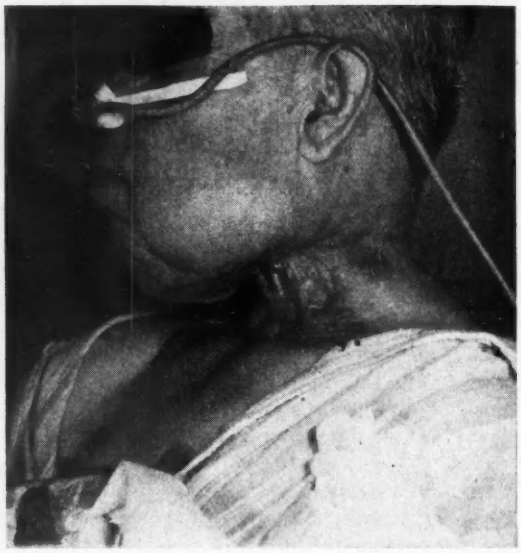

Figure 1.—Three months after operation. Pronounced lower jaw edema due to extensive removal of skin of neck with a midline visceral primary lesion and a simultaneous bilateral neck dissection.

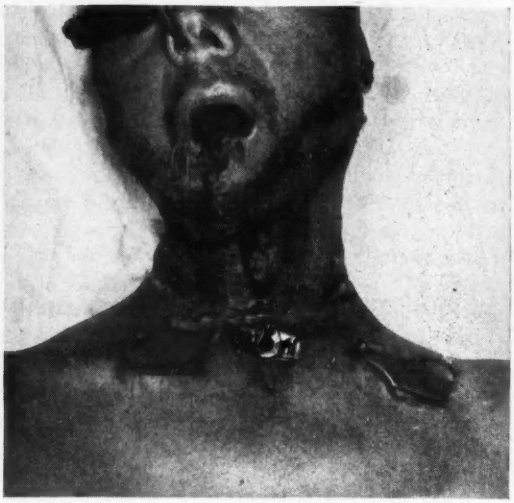

Figure 2.—Six days after operation. Minimal edema after removal of primary cancer of floor of mouth, tongue, and mandible with a simultaneous bilateral neck dissection.

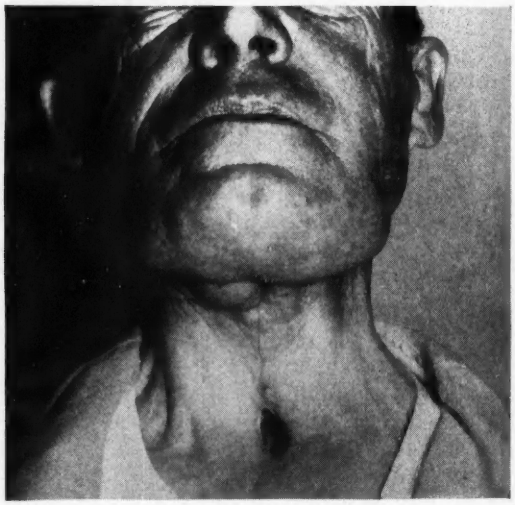

Figure 3.—Two months after operation. Minimal edema after excision of midline visceral primary cancer and simultaneous bilateral radical neck dissection. (Surgery, 31:297-306, 301, 1952.)

MORTALITY

In the three cases in which the author has carried out simultaneous bilateral radical neck dissection, the patients survived the operation. Moore and Smith[14] reported their first successful result in a similar procedure done in August 1950. In an addendum to that communication they stated that they had since performed simultaneous bilateral radical neck dissection 12 times with one surgical death due to aspiration pneumonia on the ninth postoperative day. Morfit[15] likewise reported carrying out such an operation in December 1950 and the patient recovered.

COMPLICATIONS

The complications and sequelae are dependent on many associated factors such as previous operations, simultaneous removal of large portions of the arterial bed, excision of midline viscera with added destruction of the venous return, sacrifice of overlying skin, local changes caused by irradiation, and the general medical status of the patient. These factors cause a surprising variability in the postoperative changes. One patient may have fewer alterations than are usually seen after a unilateral block dissection of the neck, while another will have extreme edema of the lower jaw and face even after a year has elapsed (see Figures 1, 2 and 3). As a rule, with ligation of the second internal jugular vein, an immediate cyanotic edema appears about the face and particularly around the lower jaw. Within one to twenty-four hours the cyanosis may disappear. The edema begins to recede by the first postoperative day. There is a tendency, however, for the edema to be more pronounced and more persistent than that which commonly occurs following a two-stage procedure, but the difference is not too great or unacceptable. In cases in which a large amount of skin was sacrificed or midline viscera had to be removed, the cosmetic alterations were more pronounced. Some edema of the larynx occurred, as

was anticipated; tracheostomy was done routinely in all cases. No organic or functional alterations referable to the central nervous system were noted, nor were there visual disturbances.

Spinal fluid pressure was measured in one case. It more than doubled within 20 minutes after the second internal jugular vein was ligated. Ninety minutes later it returned to the preoperative level without the removal of any spinal fluid.[16] The increase in spinal fluid pressure was associated with a moderate rise in blood pressure, acceleration of respiration and a drop in the pulse rate, all of which were back to within the preoperative range at the termination of the operation. In the other two cases, one patient had a sharp rise in blood pressure and a drop in the respiratory rate with return to preoperative levels in one hour, while the other had practically no demonstrable variation in blood pressure, respiration or pulse throughout the entire operation. No spinal fluid was withdrawn from any of them.

It was not necessary to infuse supplementary Pentothal® until one to two hours after the second ligation. Similar lapse of time before need for additional infusion of an intravenous anesthetic agent has been noted frequently in association with long operations on the head and neck.

INDICATIONS

Simultaneous bilateral radical neck dissection is now well enough established as a safe operation to warrant consideration of specific indications for its use. Because of the increased cosmetic deformity, the greater destruction of the arterial supply with associated impairment of healing, the increased necrosis and fistulae formation and the factor of added surgical shock particularly as regards patients as debilitated as most of them are, this operation is not recommended as a routine procedure where bilateral radical neck dissection is contemplated. It should be given first consideration, however, if the primary lesion is at the midline and there is clinically observable bilateral involvement of lymph nodes such as to necessitate transecting the primary cancer or a definitely cancer-involved lymphatic area in order to carry out a staged operation. Such primary lesions are usually in the lower lip, floor of the mouth, tongue, inferior gingiva, cervical esophagus, larynx or thyroid. (See Figures 4 and 5.) If the primary lesion is in the thyroid and is small and laterally placed, a two-stage procedure should be the treatment of choice. When the primary lesion is controlled but the initial metastases involve all the submental and both submaxillary triangles and, as is usually the case, also the mandible, the one-stage procedure is better. Where an extensive primary cancer of the anterior floor of the mouth or tongue has invaded most of the inframandibular area and mandible, even in the absence of clinical evidence of lymph node involvement, the simultaneous procedure should be considered first. The use of the one-stage procedure is not warranted for elective (so-called prophylactic) bilateral neck dissection.

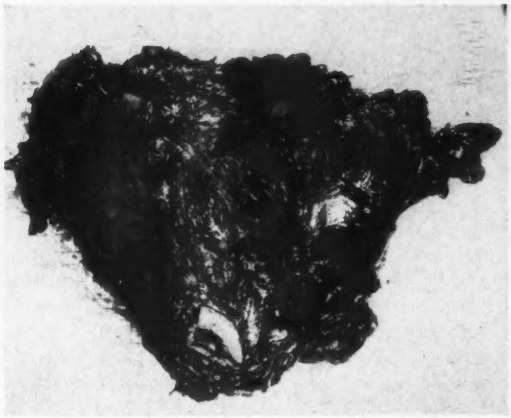

Figure 4.—"In continuity" specimen includes larynx, hyoid bone, base of tongue, pre-epiglottic space, strap muscles, preoperative tracheostomy stoma and tissues of the bilateral radical neck dissection.

Figure 5.—Specimen of floor of mouth primary cancer with part of tongue and mandible and the tissues of the bilateral radical neck dissection.

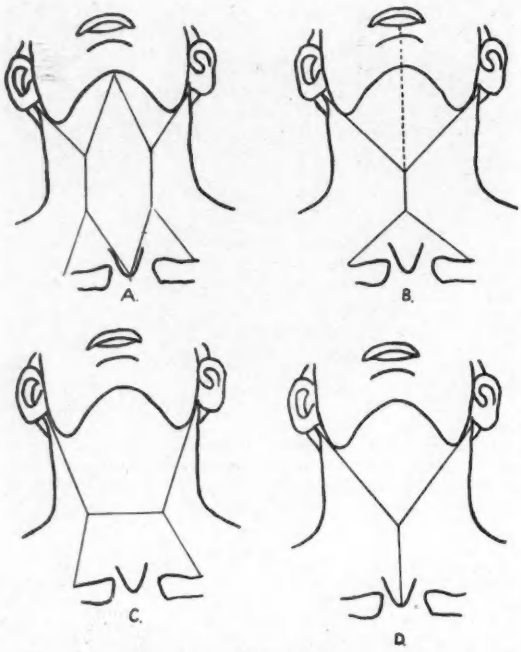

Figure 6.—Skin incisions for simultaneous bilateral radical neck dissection.

TECHNIQUE

The technique is no different from that utilized in routine combined primary excision and radical neck dissection except for the placement of the skin incision (see Figure 6). With intraoral lesions, a bilateral double "Y" skin incision could be used, leaving a wide attachment in the anterior vertical midline. The author has not used this incision, but it would seem that it might result in either limitation of the medial dissection of the neck or possible vascular impairment of the central skin flaps. Moreover, it could not be used in the presence of midline cervical lesions. A convenient incision is a double "Y" occupying both sides of the neck with the short vertical arm in the anterior midline. For intraoral primary lesions the upper triangular flap could be split in the midline through the entire thickness of the lower lip, and part of the lip removed if indicated. An "H" flap could probably be used, especially with thyroid, laryngeal or esophageal primary lesions. The author has used a single "Y" incision in operation for removal of a primary lesion of the larynx with satisfactory result.

In dealing with intraoral lesions, the dissections on both sides of the neck are done first and the excised tissues are left attached to the mandible without dissecting the submental or submaxillary triangles. The primary lesion is then excised with the mandible, cephalad and laterally, and removed "en masse" with the caudal attached neck tissues.

It probably is safer to dissect one side of the neck at a time and to tie the first internal jugular vein as early as possible, delaying the ligation of the second internal jugular vein in order to give several hours for development of the collateral venous return. Apparently there were no ill effects, however, when a team of surgeons worked simultaneously on opposite sides of the neck and the delay was not feasible.[17] Exploration of the side of the neck most involved or concerning which there is most doubt should be carried out first, so that if it is inoperable that fact can be learned as soon as possible. In dealing with midline visceral primary lesions, with the possible exception of some thyroid cancers, each side of the neck should be freed toward the midline before the primary laryngeal, pharyngeal or esophageal lesion is excised. The operation is terminated with a tracheostomy, adequate drainage and a single layer closure. A well applied pressure dressing is necessary.

300 South Beverly Drive.

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Congenital Syphilis in California

A. FRANK BREWER, M.D., and PHILIP K. CONDIT, M.D., Berkeley

• Routine serologic tests for syphilis (as required by California law governing prenatal examination) and penicillin therapy during pregnancy for infected mothers have been major factors in the prevention of congenital syphilis in California during the past ten years. In 1940 one of each 822 infants had the disease, as indicated by morbidity reports of congenital syphilis in infants under the age of one year. In 1950 the ratio was one in 8,148. To determine why congenital syphilis continues to occur, a study of the 134 cases reported over a two-year period was made with the cooperation of local health officers and practicing physicians. It showed that in 76 per cent of cases the mother did not consult a physician prior to delivery or reported so late in pregnancy that the infant was born before adequate penicillin therapy could be given. In another 15 per cent syphilis developed in the mother during pregnancy after a negative reaction to a prenatal serologic test. The other 9 per cent of cases were due to various factors, such as infectious relapse or reinfection in previously adequately treated mothers. The study indicated that most cases occur in the lower socioeconomic population groups. Seventy-four per cent of cases were in infants delivered in county hospitals.

CONGENITAL SYPHILIS is preventable. By means now available physicians and other health workers can by coordinated effort prevent the occurrence of this disease in newborn infants. A study of 10,000 pregnancies at the Philadelphia General Hospital[3] indicated that penicillin given in adequate amounts—2.4 million units and up, during pregnancy—to women with early acquired syphilis, reduced the risk of an unfavorable outcome to the same order of magnitude as in a normal non-syphilitic group of pregnant women. Without treatment, however, approximately 82 per cent of such pregnancies have an unfavorable outcome; 42 per cent of the infants are stillborn or die within the first few hours or days of life, 40 per cent are living infants with active syphilis, and only 18 per cent escape infection in utero and are normal. With treatment the expectancy relative to the delivery of a living normal full term or of a premature infant is equal to that of the control group, the incidence of stillbirths is 2 to 3 per cent, and the possibility of having a living syphilitic infant falls to approximately 1 per cent.

Two laws enacted in California in 1939 were designed to assist in the prevention of syphilis. One requires both partners in an intended wedding to be examined and to have a test for syphilis before the wedding. The object is to discover syphilis and to place an infected person under treatment before the infection can be communicated to an innocent partner. The other law requires a physician attending a pregnant woman to take a blood test for syphilis at the time of the first professional visit or within ten days thereafter. All laboratories that perform prenatal blood tests send a copy of the report to the State Department of Health and local health officers are in turn notified of positive reports in residents in the area of their jurisdiction. The earlier the diagnosis is made and treatment provided, the better the prognosis for both mother and child.

Congenital syphilis derives from the reservoir of syphilis in the adult population. During the calendar year 1950, the rate for all types of syphilis in California was 98.1 reported cases per 100,000 population. This is considerably less than the rate for the United States as a whole, which was 155.1 per 100,000 population for the reporting year 1950.[4]

Chart 1 shows the reported cases of syphilis by stages for California for the years 1940 to 1951. The number of cases was declining prior to World War II, but this trend was reversed with military and industrial mobilization and there was a rapid increase of 35 per cent in the number of cases reported annually between 1940 and 1943. In the latter year 29,346 cases were reported, the record peak for California. The number of cases remained high during the war years and it was not until 1948 that the prewar downward trend was re-established. This observation may have some significance in relation to the current period of industrial and military mobilization. Although the trend at present continues downward, it shows a tendency to level off.

In 1950 and 1951, for each patient with primary or secondary syphilis reported in California, ten

From the Division of Preventive Medical Services, California State Department of Public Health, San Francisco.

Presented before the Section on Public Health at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

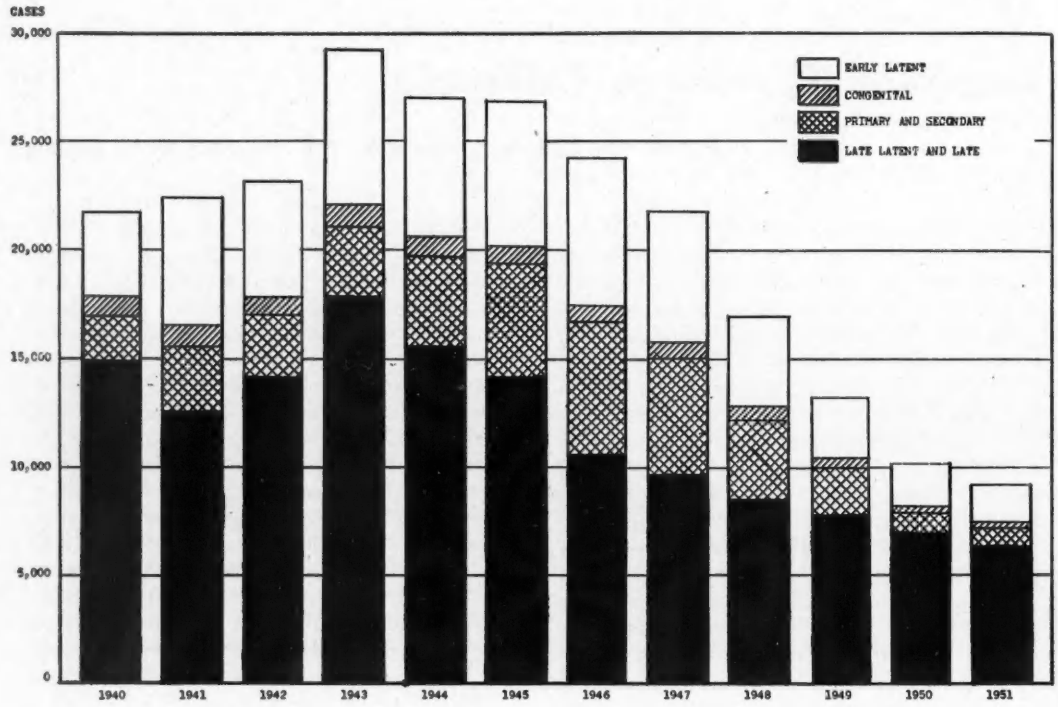

Chart 1.—Reported cases of syphilis in civilians in California, 1940-1951.

others were reported in the latent or late stage of the disease. This raises question as to how ultimate control of this disease will be achieved when 10 out of 11 cases pass through the most infectious stage before they are discovered.

Chart 2 gives data on the total number of reported cases of congenital syphilis and on congenital syphilis in infants less than a year old. In 1940, 905 cases were reported, 136 of them in infants under one year of age. In 1950 there were 377 cases reported, 30 in infants. During this period the number of births in California increased from 111,840 in 1940 to 244,457 in 1950. In 1940 one infant in each 822 born in California had a diagnosis of congenital syphilis; in 1950, one infant in each 8,148 (Table 1).

The cases of congenital syphilis that are diagnosed before the patient reaches the age of one year do not, unfortunately, represent the total problem. In 1940, for each case reported in an infant under one year of age there were 5.7 cases reported in persons over that age. In 1950, there were 11 times as many cases reported in persons over one year of age as there were in infants under that age. (See Chart 2.)

In light of the previously mentioned report[3] that treatment of the mother during pregnancy with penicillin is nearly 100 per cent effective in protecting the newborn infant from congenital syphilis, the new cases which appear must be attributed to failure in the fields of preventive medicine and public health. With this in mind, the authors began a study in 1949 of each reported case of congenital syphilis in a person under one year of age to determine if

TABLE 1.—*Live Births and Reported Cases of Congenital Syphilis Under One Year of Age and Rate per 100,000 Live Births, California, 1938-1950*

Year	Live Births	Reported Cases of Congenital Syphilis Under 1 Year of Age	Rate Per 100,000 Live Births
1938	101,844	163	160.0
1939	103,605	137	132.2
1940	112,287	135	120.2
1941	125,190	93	74.3
1942	154,567	74	47.9
1943	174,420	74	42.4
1944	179,123	114	63.6
1945	184,380	100	54.2
1946	218,484	128	58.6
1947	243,808	163	66.8
1948	239,518	105	43.8
1949	244,905	56	22.9
1950	244,457	30	12.3

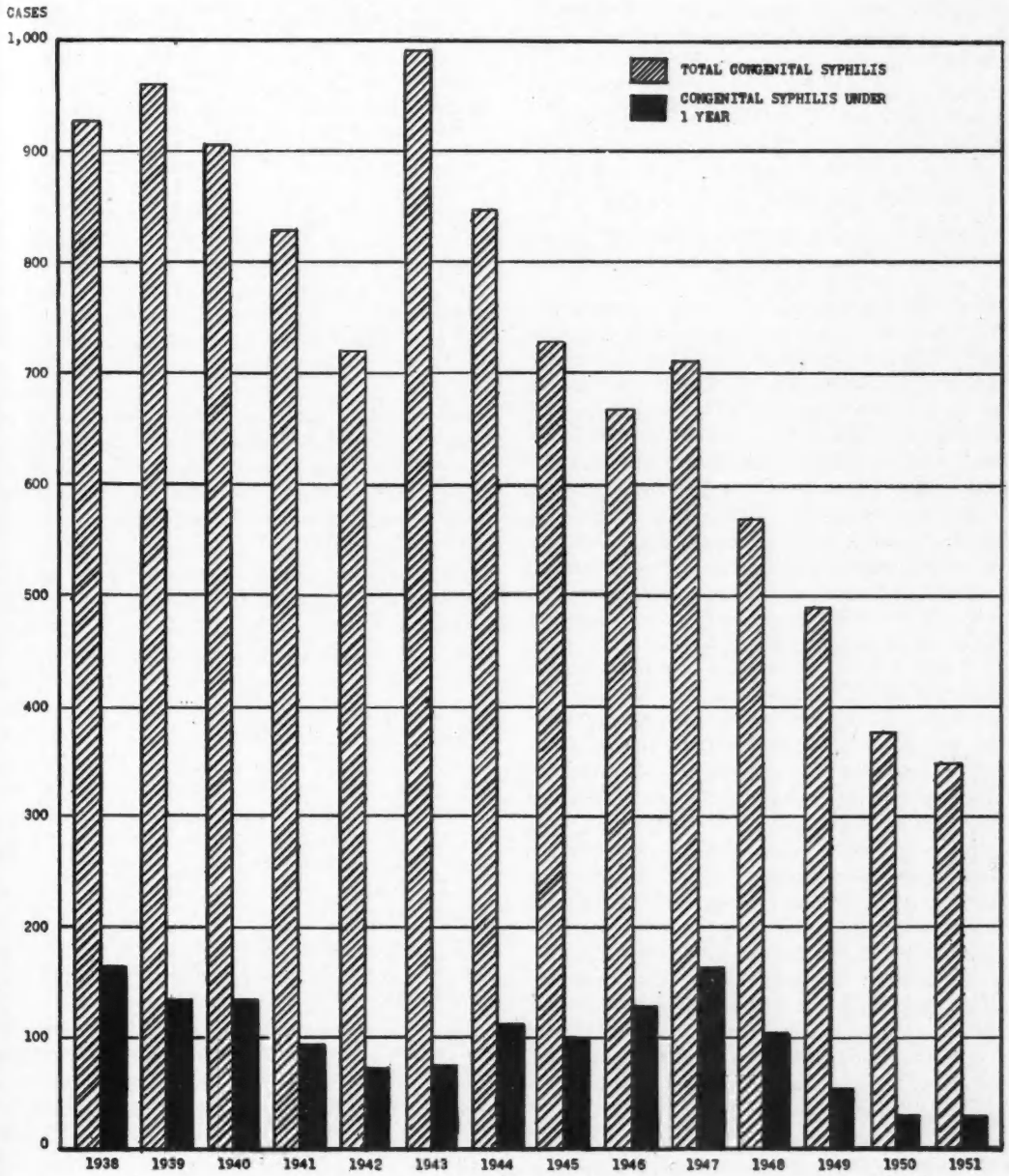

Chart 2.—Reported cases of congenital syphilis in California, 1938-1951.

possible how such tragedies could be averted. Over a period of two years data were collected on 134 infants.

Race and Sex: As regards racial origin, 34 per cent of reported cases occurred in Negroes and 41 per cent in persons in the Spanish-American population group. (Negroes constituted 5.6 per cent of the population of the state in 1950; the proportion of Spanish-Americans is unknown, but obviously they are a minority group.) Fifty-two per cent of the infants were females and 48 per cent were males.

Marital Status of Mothers: In a similar series,[2] studied in Massachusetts, 11.2 per cent of the mothers of the infants were unmarried. It is estimated that 2 to 3 per cent of all the women delivered of babies in that state were unwed. While complete data

on marital status was not obtained in the present series, the information that was obtained indicated that the proportion of unwed mothers was high.

Place of Birth: 98 per cent of the infants were delivered in a hospital. In California 98 per cent of all deliveries occur in hospitals. Seventy-four per cent of the hospital deliveries were in county hospitals and 24 per cent in private institutions.

Diagnosis: 23 (17 per cent) of the 134 infants reported as having congenital syphilis were later determined, by observation and serological tests, not to have the disease, and no treatment was given. (The morbidity report cards were sent in shortly after the birth of the infant, when a tentative diagnosis of congenital syphilis was under consideration, but before completion of the observation period necessary to substantiate or rule out the diagnosis. These cases should not have been reported.)

In 30 cases (22 per cent) the diagnosis was based on presumptive evidence, penicillin therapy was given on a prophylactic basis, and the presence of active syphilitic infection in the infant is open to question. The diagnosis of congenital syphilis is fraught with difficulty and, owing to the passive transfer of maternal reagin, it may be necessary to observe an infant with repeated quantitative blood tests for a period of three to six months following birth before a definitive diagnosis of active congenital syphilis can be established or ruled out. Darkfield examinations of the serum exudate from any skin or mucosal lesions and x-ray studies of the long bones may also be indicated. Since penicillin therapy is readily available, carries little therapeutic risk and is nearly 100 per cent efficacious, the attending physician may justifiably question whether the prolonged delay occasioned by a doubtful diagnosis serves the best interest of the patient. The information provided by this study indicates that some physicians are adopting the policy that where reasonable doubt exists, it is better to treat the infant with penicillin on a prophylactic basis than to await the findings of an extensive period of clinical observation and laboratory studies.

It thus appears that current statistics are weighted with reported cases in which penicillin was given to the infant as a precautionary measure for the prevention of congenital syphilis instead of for the purpose of curing a known active infection. If we are to have an accurate measurement of the occurrence of this disease, it is desirable that, in reporting, distinction be made between cases in which the presence of an active syphilitic infection in the infant has been clearly established by clinical and laboratory findings and those in which the diagnosis in the infant is based on epidemiological and presumptive

TABLE 2.—*Live Births, Infant Deaths and Mortality Rate for Syphilis Under One Year of Age, California, 1938-1950*

Year	Live Births	Syphilis Deaths Under 1 Year of Age	Rate Per 100,000 Live Births
1938	101,844	46	45.2
1939	103,605	41	39.6
1940	112,287	31	27.6
1941	125,190	26	20.8
1942	154,567	31	20.0
1943	174,420	27	15.5
1944	179,123	28	15.6
1945	184,380	28	15.2
1946	218,484	30	13.7
1947	243,808	22	9.0
1948	239,518	22	9.2
1949	244,905	9	3.7
1950	244,457	7	2.9

evidence. The former cases should be reported as *congenital syphilis* and the latter as *congenital syphilis—epidemiological*, the qualifying term indicating that penicillin therapy was given to the infant for prophylaxis because epidemiological data indicated probable exposure.

No case of congenital syphilis in this series resulted directly from a failure on the part of the physician to carry out a prenatal test. In a similar series[2] studied in Massachusetts, three such cases are recorded. An analysis of a sample of California birth certificates for 1951 reveals that out of approximately 1,600 deliveries in which no prenatal test was taken, the reason given by the attending physician in 64 cases was that it was overlooked. The provision of the California Health and Safety Code[1] with regard to prenatal tests is clear and concise: "Every licensed physician and surgeon or other person engaged in prenatal care of a pregnant woman, or attending such woman at the time of delivery, shall obtain or cause to be obtained a blood specimen of such woman at the time of the first professional visit or within 10 days thereafter."

If the 23 reported cases in which the infant was subsequently shown to not have congenital syphilis and the 30 cases in which treatment was given on a prophylactic basis in the absence of a definitive diagnosis are deducted from the series, 81 cases remain.

The principal factors resulting in the occurrence of congenital syphilis in these infants follow:

Failure to Obtain Prenatal Care: If the woman made one visit to a physician prior to delivery, it was considered for the purpose of this study that she had received prenatal care. Forty-two women (52 per cent) received no prenatal care, first coming under medical supervision when they entered the hospital for delivery. An additional 17 women (21 per cent) reported to a physician's office or clinic

only once, had a blood test which was positive for syphilis, then did not return and were not located until they reported for delivery. Of the 39 who received prenatal care (including the 17 who reported only once), 18 made their initial visit to a physician during the third trimester, 11 during the second trimester, and only ten during the first trimester.

In 12 cases (15 per cent) the mother had had a prenatal serological test that was negative for syphilis. When the mothers were examined later, after congenital syphilis was diagnosed in the infants, one had primary, two had secondary, and nine had asymptomatic seropositive early syphilis. In five of these cases a definite history of exposure to an infected marital partner during pregnancy was obtained. In the other seven it must be assumed that the mother was either incubating syphilis in the seronegative stage at the time the prenatal blood test was made or was infected after the test was made. A "false negative" report resulting from laboratory error on the initial test is also a possibility.

Inadequate Penicillin Therapy: In four cases the mother did not report for prenatal care until two weeks or less from the time of delivery and although the diagnosis of syphilis was established and treatment begun, delivery occurred before the course of treatment was completed.

Infectious relapse or reinfection occurred in two cases. One patient with a history of adequate therapy with penicillin, mapharsen and bismuth at the time of the birth of her first child was examined nine months later in the seventh month of her second pregnancy. She received five injections of mapharsen and three of bismuth before delivery and, when next examined in the clinic, four months after delivery, mother and baby had serological tests negative for syphilis. The mother had two more serological tests, both "negative," one two months later, and the other seven months later when she was in the fourth month of a third pregnancy. In view of the known adequate previous therapy, the negative results of serologic tests and the interim birth of a normal infant, it was decided that retreatment was not necessary. The patient did not return to the clinic for postpartum examination for nearly a year, at which time her third infant was eight months old. At this time the result of a Kahn test of the mother's blood was "positive" and the result of a Kolmer test was 33333. The result of a quantitative Kolmer test of blood from the infant showed titration at 2048 units with no end-point reached. The infant was mentally retarded, unable to sit up by himself, had prominent parietal bosses and other stigmata of congenital syphilis. This case of infectious relapse or reinfection is reported in some detail because it illustrates the difficulties sometimes encountered in the management of syphilis in pregnancy.

In a second case, the history revealed that the mother had received 30 injections of an arsenical compound and 20 of bismuth in 1944 for secondary syphilis and 3 million units of penicillin when pregnant in 1948. Twelve months after the 1948 course of treatment she was delivered of her fourth infant which was found at the age of two months to have a serologic titer of 1024 Kolmer units and a darkfield-positive annular lesion on the face.

Biological "False Positive" Serological Tests: Two cases were reported on the basis of weakly positive or doubtful reactions in serological tests. One infant, ten months of age, had bronchopneumonia. The other, eight months of age, had a skin eruption. Both infants received penicillin but subsequent investigation did not bear out the diagnosis of syphilis. Results of repeated serological tests on both mothers were negative. The inconclusive serological reports on the infants were probably biological "false positive" reactions; the skin eruption a vaccinia with secondary infection resulting from a smallpox immunization.

Clerical Error: In one case a serological test report of "positive" was mislaid and the mother received no therapy before delivery.

Treatment Failure: There was one apparent failure of treatment—in a woman who received 4.5 million units of penicillin at the sixth month of pregnancy because of serological tests positive for syphilis. When the infant was four months old a skin eruption developed and there was a marked rise in titer in the quantitative serological tests.

SUMMARY OF OBSERVATIONS

In a series of 134 infants under one year of age reported to the State Department of Health as having congenital syphilis, 23 were found upon further observation not to have the disease, and 30 others had been given penicillin on a prophylactic basis before there was certainty of the diagnosis of syphilis.

In the remaining 81 cases, the principal factors resulting in the reported infection of the infant were:

	Number of Cases
No prenatal care	42
Mother visited physician only once before delivery	17
Infection (or incubation) in mother after initial negative prenatal test	12
Insufficient penicillin therapy before delivery	4
Infectious relapse or reinfection	2
Biological "false positive" serological tests	2
Clerical error (laboratory report mislaid)	1
Treatment failure	1

RECOMMENDATIONS

Congenital syphilis can be prevented only if the pregnant woman receives prenatal care. In 77 per cent of the cases in the present series, infection occurred either because the mother did not obtain any medical supervision during the prenatal period or because the prenatal supervision she did obtain was too little and too late. Physicians and health workers should redouble their educational efforts to get women to seek medical care early in pregnancy. A prenatal serological test positive for syphilis should be considered a medical emergency and every reasonable effort made to ensure the patient's return to the clinic or physician's office for diagnostic study and treatment. Physicians should not hesitate to request the assistance of their local health department staff for this purpose. Health departments should ascertain whether women for whom "positive" prenatal test reports are received from the State Department of Public Health have remained under medical supervision. This service should be expedited and given a high priority.

Congenital syphilis occurs most frequently in the lower socioeconomic population groups (Negro, Spanish-American), among infants of unwed mothers and among infants delivered in county and municipal hospitals. At least two serologic tests for syphilis, one early and the other late in pregnancy, should be made on women in the above categories; on all women known to have been sexually promiscuous; women having a history of any venereal disease; and single, divorced or separated pregnant women. The attending or resident physician admitting a patient in labor as a hospital service should have a serologic test done unless satisfied that one has already been done during this pregnancy.

To guard against the possibility of infectious relapse or reinfection, women adequately treated for syphilis before pregnancy and who are "seronegative" should have blood tests at least once in the first and second trimesters of pregnancy and monthly during the last trimester.

Women who have been adequately treated for syphilis but are still "seropositive" should be retreated with penicillin during each succeeding pregnancy.

All patients infected with syphilis and the other venereal diseases should be questioned about contacts.

All cases of venereal disease should be reported by physicians.

2180 Milvia Street.

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Delinquency in Women

JAMES E. McGINNIS, M.D., *Los Angeles*

• *From observation of some 1,000 women who were committed to a California correctional institution because of felonious offense it was concluded that:*

1. Delinquency results from certain identifiable factors, particularly basic defects in early family relationships, various aberrant psychological states including many forms of mental illness; physical illness or injuries, particularly those producing brain damage and resulting in abnormal psychological conditions; general environmental factors, and specific environmental factors.

2. Certain personality-types and certain life-environmental situations appear to be associated with certain patterns of offenses.

3. Correction and rehabilitation may be achieved to a greater degree as correctional institution treatment programs are increasingly implemented with psychiatric personnel, and as increased guidance and support are made available through parole divisions.

OBSERVATIONS IN THIS PAPER are based upon the psychiatric study over the past five years of approximately a thousand women in the state of California convicted of one or more felonious offenses. For the most part they were observed at the California Institution for Women, the only California state correctional institution receiving adult female offenders. The author is a part-time consulting psychiatrist there.

The institution has approximately 400 inmates ranging in age from the second decade to old age. All are convicted of felonies from petty theft with prior conviction through the gamut of human delinquent behavior, including forgery, grand theft, burglary, robbery, arson, and murder. Under California law the inmates are received on indeterminate sentences, varying with the offense, and the actual duration of term is fixed by an Institution Board following a period of institutional residence.

Consideration of this group is given in terms of etiological factors, patterns of offenses, the institution program and parole.

ETIOLOGICAL FACTORS

Etiological factors may be considered in five general categories: (1) Basic defects in early family relationship; (2) aberrant psychological states, including deviations sufficient in degree to indicate the diagnosis of actual mental illness, and including, as well, states of mental deficiency; (3) physical factors; (4) general environmental factors; (5) specific environmental factors.

The incidence of basic defects in early family relationships in the lives of the delinquent women studied was so high as to be considered almost universal for the group. General parental neglect and lack of supervision, parental delinquency, parental alcoholism, parental mental illness and parental incompatibility are deleterious factors frequently described, as are low parental cultural and sociological standards, parental oversolicitude, stern and aloof parental direction, and parental rejection.

These factors in the early lives of women delinquents often are present in very full degree. They, and other similar elements, often are particularly emphasized in the presence of parental divorce and the subsequent advent of a step-parent.

An illuminating related quotation, from an "incorrigible" adolescent: "My father, he actually isn't any good. I can't respect him. I suppose, of course, I like him, because he is my father, but as a person I don't like him at all. Mother's o.k., but she isn't very affectionate. Even if I hadn't seen her for two years, I could walk in and it would just be, 'Oh, hello, there.' They never keep their promises. Yet I can't ever be mad at them. I keep going back for more. I can reason things out with anything but my family."

The parents of whom she spoke are divorced. Her husband is in San Quentin prison. She is 19, intelligent, pretty, and she had become addicted to heroin and had participated in burglary.

Aberrant psychological states likewise are often present in delinquent women. They were of variable degree and were clearly related to the commission of the delinquent act, sometimes specifically, and in some cases generally in that they had contributed to the formation of a total life situation which caused seriously delinquent behavior to become inevitable.

Mental deficiency is not common, but where it is present the concomitant factors are easy suggestibility, lack of judgment, feelings of rejection and

Read at the 107th annual meeting of the American Psychiatric Association, Cincinnati, May 11, 1951.

the need to win acceptance—factors which lead directly to delinquency through the influence of delinquent companions.

Psychotic states occur rather rarely, but when present are often considered, as might be expected, to be intimately connected with the commission of the offense. Psychoneurosis is common. Post-traumatic and postencephalitic personality disorders constitute a continuing problem. Sexual deviations and the symptom complex that has been designated by the term "personality disorder" likewise are of high incidence.

Most of the women who do not have any of these more or less specific conditions have various combinations of personality defects which, while not single diagnostic entities, often motivate behavior in the direction of the social failure of delinquency. Among such defects are dependence, general inadequacy, immaturity, intermittently repressed resentment, antisocial aggressiveness and easy loss of adequate emotional control.

Alcoholism and narcotic addiction, arising earlier as corollaries of these states of maladjustment, may contribute additional pressure toward delinquency, while a toxic substance, usually alcohol, frequently is of immediate influence in the commission of felonious offense.

Physical factors alone, other than the physical illness producing brain damage or occurring in conjunction with addiction, are not high-ranking etiological determinants. Occasionally, chronic illness may contribute to the creation of special need with an effort to seek a solution through (usually) a nonviolent offense such as burglary or forgery. More important are the long-time reactions of persons ostensibly handicapped by the presence of physical abnormalities like obesity, scars, tallness or shortness, a large nose, or big ears.

General environmental factors are of considerable importance. While endogenous factors appear to make the primary contribution to delinquent behavior, exogenous environmental factors certainly in many instances provide the example or supply the incentive without which many delinquent acts would not occur.

An environment of associates whose influence is directly toward delinquency is important in causing a woman who otherwise might not do so to commit a delinquent act. The associate may be a casual neighborhood acquaintance, a lover, a homosexual friend or a husband inclined to delinquency. But, most importantly, there often must be, in addition, a general lack of reasonable environmental security, and particularly the absence of any person accepted by the potential offender as offering warm confidence and counsel. Financial stress, loss of work, lack of occupation, gambling, alcoholism and narcotic addiction all may direct the offender toward delinquency-tainted environments.

Environmental dislocation through migration to a place where the social order is more complicated may be a factor causing delinquency in susceptible women. The change is particularly distressing to persons under the handicap of inadequate vocational training, which in itself may be an important factor in the development of delinquency.

Finally, specific environmental factors—often it almost seems by action of a perverse fate—may give the final impetus to push into delinquency a woman ready for transgression. Such factors are of every type and variety, animate and inanimate. The presence of a knife or a gun or other lethal weapon lying at hand as the potential offender experiences a catastrophic episode of rage or fright may almost create the crime of murder or manslaughter. "Opportunity" in the way of inadequately protected funds or the key in an unguarded automobile may tempt beyond weak resistance. Or the specific environmental factor leading to crime may be the need of a beloved person, or anger at rejection or a feeling of hopeless inferiority arising from perhaps a trifling rebuff.

PATTERNS OF OFFENSES

Although each woman offender must be regarded as having particular elements of difference from all others, there are in general certain personality types and certain life-environmental situations which seem to be associated with certain patterns of offenses. The following typical examples are composed from numerous histories.

1. One pattern is that of an adolescent girl, usually of relatively low intellectual endowment and with feelings of rejection by her parents, in a rural environment. Unmarried, she becomes pregnant, leaves home for a more urban area, finds difficulty in self-support, then drifts into, successively, prostitution, narcotic addiction, and forgery, all over a period of years. The degree of intelligence, the degree of addiction, and the duration of delinquency are important in the outlook for freedom from delinquency following institutional training experience, but the prognosis generally is dubious.

2. Another adolescent girl, likewise from a rural environment, of good intellectual endowment, strong physically, encounters long-time stress in relationship to her parents, is rebellious, resentful, and nonconforming, and leaves home to encounter chance-met delinquent male companions with whom she participates in delinquent acts of violence, such as robbery. The prognosis may be favorable.

3. A middle-aged woman, married, divorced or widowed, who usually has served in some capacity on the fringes of medical practice during the earlier

part of her life, such as partial completion of nurses' training, work as a practical nurse in sanitaria, or graduation from office receptionist to a physician's assistant, then has chance encounter with the practice of abortion, and later proceeds to the operation of her own abortion practice. Her intellect level varies. The prognosis is very uncertain, and repeated practice of abortion the usual act in violation of parole.

4. The alcoholic check-writer, of the earlier or middle decades of life, whose variety is legion, whose early parental relationships may be marked by oversolicitude, and whose check-writing activity may initially be influenced by other delinquent persons. Backgrounds and personalities of persons in this group are considerably diverse, but characteristics are irresponsibility, lack of insight and easy optimism. The prognosis varies.

5. A middle-aged Negro of dull-to-average intellectual endowment, who has usually served in a humble occupational capacity and has lived under modest economic circumstances, who stabs or shoots her lover, or husband, or feminine rival in a quarrel in which alcohol plays a part, and who usually pleads guilty to manslaughter. The prognosis may be excellent or poor.

6. A youthful bookkeeper and secretary, of good intelligence, who has experienced a variety of stresses in her early family relationships, who possibly is considerably ambivalent toward the mother, who encounters temptation and opportunity through an employer whose methods of accounting may be inadequate or in some other similar fashion, and who then commits grand theft, often of large sums. Pressures involving gambling, relationship to men, or even of general family need, may be involved. The prognosis is uncertain to favorable.

7. An adolescent girl or youthful woman who reacts in terror to childbirth in an illegitimate pregnancy, and who soon thereafter kills the infant. Adequate parental support usually is lacking. The prognosis in the absence of major mental deficiency usually is favorable.

8. The young woman of average intelligence who, after early years of uncertainty and stress, acknowledges the presence of homosexual orientation, with perhaps the development of a homosexual relationship, and who, in a state of chaotic emotionality embarks upon repeated acts of delinquency, as forgery. The prognosis is poor for any early change.

9. A woman, youthful to middle-aged, who gives a history of prior severe head trauma or of encephalitis, together with long-time subsequent symptoms of impulsiveness, poor control, and repeated delinquent acts, often of a relatively minor type, but occasionally of the greatest violence. The prognosis is poor.

10. A woman of youth, middle, or old age, whose offense is premeditated murder. The evaluation of these women does not lend itself to generality. Long-time and major stress usually is involved. The prognosis is favorable more often than not.

THE INSTITUTIONAL PROGRAM

The great majority of these offenders, and of others guilty of numerous additional offenses, whether those offenses be petty theft or murder in the first degree, are destined for ultimate release, and it is particularly for these women that the rehabilitative measures in institutional life should be planned and coordinated, from the very hour of initial admission.

The initial induction experience, with group meetings designed to acquaint the women with the general organization and purpose of the new environment, together with extensive personal studies, in itself constitutes a therapeutic measure of considerable import, with a strong influence toward personal reorientation and the directing of future activities toward achievement. Women offenders, like many others in the general population, often have no conception of the correctional institution as a rehabilitation center, and their anxiety, depression and personal disorganization are likely to be severest at the time of admission, owing to the trauma of the offense itself, the time in jail, the trial and the final sentence. The relief which comes with the realization of the treatment program is often followed by new hope and by at least an initial determination to succeed.

Through the group of personal studies, including sociological, vocational, religious, physical, psychological testing, and psychiatric, the woman as a functioning person can be evaluated and the apparent etiological factors in her delinquency recognized to some degree. Thereafter, ideally there is created an individualized program for each inmate, including the correction of remediable physical defects, formal education, vocational training, participation in inmate group activities and psychiatric treatment to the degree in which it is available.

It is obvious that psychiatric diagnosis and treatment can be of immense benefit to the inmate group, and that this phase of the treatment program profitably can be utilized to the degree seen in the best of private practice—a degree which is not remotely approached in many correctional institutions. Recognition of this need for psychiatric treatment, which has come with the increasing public acceptance of the value of psychiatry, is acknowledged every day by courts, judges, probation officers and

participating attorneys, even to the point that delinquent individuals sometimes are admitted to correctional institutions upon the major premise by the committing judge that only in this way will they be placed in a situation where adequate psychiatric aid will be available to them.

This admirable theoretical concept may, however, and often does far exceed the correctional institution's ability to fulfill, in view of the limited available psychiatric services.

The attitude and interest of the psychiatric department, or of the individual psychiatrist, is of first importance. Rejection of the "bug doctor" or of the "psych" will always be shown at first by some inmates, but if the emphasis is upon a permissive and friendly early relationship, without reference to the inmate as a "criminal," but instead with consideration of her assets and liabilities as a functioning human being who has failed in one phase of her social relationships, then it will be found that the inmate group not only will be receptive to the suggestion of psychiatric treatment but often voluntarily will seek it.

There is the additional observation that the total institutional program of living, properly oriented and directed, in itself becomes a therapeutic experience. The correctional officers in charge of particular groups of inmates in residence situations, the vocational instructors, the class-room teachers and all other institutional personnel, to degrees depending upon their personal characteristics and the closeness of contact with the inmate groups, become members of a therapeutic team, under the direction of the superintendent, whose philosophy, personal characteristics and total qualifications may considerably determine the therapeutic atmosphere of the entire institution.

The therapeutic influence of these various persons does not stem from direct counselling contracts (although counselling is often an integral part of the particular activity, directly or indirectly) but more strongly from personal examples, through personal attitudes, beliefs, and virtues.

PAROLE

Parole, the period toward which the training program is presumably oriented from its inception, represents a time of trial in which more succeed than fail. The probability of parole success or failure is often predictable on the basis of the assets and liabilities of the person involved, as evaluated at the conclusion of her institutional stay. Sometimes the evaluation of a candidate for parole would seem to indicate almost certain failure. Yet the parole may be granted upon consideration of the degree of the offense, the limits of the imposed term or the very fact that the judgment of those concerned is not infallible.

Parole failure usually occurs through stress of forces similar to those which brought about the initial delinquency, although the specific offense may differ. Or violation of parole may come about through a variety of relatively minor acts of noncompliance. The amount and type of support given a parolee is vital in parole success—support such as can be given by interested relatives, by adequate financial resources or by satisfactory vocational placement.

Limitations of the parole staff often are extreme, by reason of budgetary considerations, in the face of a task which demands much.

Extensive parole activity of a psychiatric social-work type during the early months of parole could presumably avert parole failure in many cases in which the parolee is not quite adequate to making the transition from a regulated institutional life to an unregulated outside existence. The attitude of the community toward previously delinquent women often is inimical to success of parole.

1200 North State Street.

The Auxiliary Treatment of Psychotic Women

Group Therapy for Their Husbands

GENE GORDON, M.D., and KARL M. BOWMAN, M.D., San Francisco

• Group therapy for the husbands of hospitalized psychotic women relieved the anxiety and feeling of guilt of the husbands and led to better communication between husband and wife. It was particularly helpful just before and after the wife came home from the hospital. The group meetings saved various members of the hospital staff considerable time which they otherwise would have had to devote to the husbands individually.

WHEN A MARRIED WOMAN experiences a psychotic break and has to be hospitalized, it creates serious problems for her husband. Besides carrying on his job, he is saddled with the children and the household. He must get some woman of the family to help or a housekeeper, but still it involves extra work for him. These additional burdens fall on him when he is so anxious about his wife that it would be hard for him to carry on even his usual work.

The wives in the hospital are not thereby removed from family concern, and visits from a tired anxious husband do not make them feel any better. They feel guilty enough about abandoning their families; and although the men usually make a valiant effort to conceal their own anxiety, no one is fooled and the hospitalized wife feels even more guilty. When the wife is discharged and comes home, the husband's anxiety comes to bear on her even more heavily.

The husbands manifest their anxiety in many ways. Some come directly to the wife's therapist and ask for psychiatric help. Others turn the brief conferences which relatives are accustomed to have with the patient's doctor into therapeutic hours for themselves. They do this rather subtly. First they ask how the wife is getting along, when she will be home, and so on. Gradually this turns into questions about how decisions they themselves have to make will affect their wives. "If I take a business trip to Oregon, will she be upset?" "She's coming home this weekend and her sister wants to drop in; do you think that's all right?" Such men may take up an hour or two a week of a busy therapist's time without realizing that they are really asking for help with their own emotional problems. When this is pointed out to them, they may accept the interpretation with alacrity, as if they knew they were asking for psychiatric help, but did not dare to come out openly. Equally common is a persistent denial by the husband that his problems are anything other than those created by his wife's illness.

At the Langley Porter Clinic husbands of inpatient women who were willing, were usually referred to the outpatient clinic for individual psychotherapy. Facilities are limited, and frequently they had to wait many months before a therapist could be found. That was the situation in May 1951, when the group-therapy project herein reported upon was undertaken. One of the authors was resident psychiatrist on a ward for female inpatients, and found himself spending increasing amounts of time with the husbands of his patients. At least four of these men were on the waiting list for outpatient treatment. The therapist himself had no time for formal or informal therapy with these men. Furthermore he was reluctant to treat both husbands and wives on an individual basis simultaneously. Yet there was a clear need, and failure to satisfy it was obviously interfering with the therapist's primary objective, the treatment of his inpatients.

These were the considerations that led to the group-therapy project with the husbands. The group method has been used in child psychiatry with parents of disturbed children. At the Langley Porter Clinic, the parents of psychotic adolescents have also been treated in groups. A review of the literature disclosed no published work on group therapy with the husbands of hospitalized women.

The group started with seven members in June 1951. It was planned as an "open" group; that is, members could be added as circumstances permitted up to a maximum of eight at any one time. The group meets once a week for an hour and a half in the evenings in a small conference room at the clinic. At the time of this report the meetings had continued regularly for nearly 11 months. A total of 12 men had been in the group at one time or another; of the original seven, five still were attending.

From the Langley Porter Clinic.

Presented before the Section on Psychiatry and Neurology at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

No attempt was made to select the husband on the basis of the diagnosis of the wife's illness. As it happened, eight of the 12 wives were diagnosed as schizophrenic; the other four were primarily depressed. Only one woman did not have electric shock therapy and/or insulin therapy in addition to psychotherapy. The group leader was also therapist for five of the wives. Each wife was actually in the hospital when her husband joined the group; all the wives were discharged from the hospital and went home in the course of the meetings.

The therapist saw each man individually before he joined the group to get some background information, and to eliminate those for whom group therapy did not seem indicated. Only two men who were interviewed did not join the group. One was invited but did not attend. Another, manifestly schizophrenic, was referred for individual therapy.

Most of the men were in their early thirties; three were about forty years of age. As to occupation, there were three engineers, three salesmen, a chemist, a postman, a plumber, an accountant, a bartender, and a regular army officer. It was substantially a middle-class group. With one exception, all the men had children; in one case the child was adopted. Five of the men could be loosely characterized as passive-dependent personalities, mildly psychoneurotic. Four had more severe neuroses, and three might be considered schizoid personalities. Three men had had some psychotherapy previously. One was hospitalized for a year and a half with combat fatigue; one man had had a year of analysis; a third had been in therapy with a clinic social worker for several months.

The central theme of the group, one which was repeated in many guises, was an overwhelming, immobilizing guilt. Each man was saying in one way or another: "I feel responsible for my wife's breakdown. I don't know exactly what I did, so I'm scared I may go on doing it. Then she'll stay sick, or if she does recover, she'll have a relapse." The overt expression of this underlying guilt-theme varied from man to man. Some were fairly direct: They had been too selfish in their hobbies, or delinquent in showing affection to their wives. In the first meeting many men said how hard it is to tell their wives they like a new dress or enjoy a meal. But this directly expressed guilt had a spurious quality to it, like the confessions that men make to please an inquisitor.

A more significant manifestation of their guilt was the overprotection the men displayed toward their wives. They tended to project their own anxieties; for example, they were afraid that other people's opinions about mental illness might upset their wives. Some avoided social contacts lest someone make an untoward remark about insanity. Some men did all the shopping so that the wives would not be subjected to critical scrutiny in the shops. The men tried to reassure each other that mental illness is just like appendicitis, that attitudes of condemnation are archaic, and that it is surprising how many people turn out to have crazy relatives. They agreed that people today are really quite understanding about mental illness.

Yet many of the men had gone to some length to conceal their wives' condition. One man told people his wife was travelling. Another said his wife was hospitalized with a back injury. Generally the group condemned these subterfuges and reassured those who had used them; but it was not until much later that the group returned to this subject and faced the fact that the fears they attributed to their wives were their own fears, and the misconceptions they ascribed to the public were their own misconceptions.

HUSBAND-WIFE COMMUNICATION

The tendency to overprotect showed itself in other ways. Many of the men continued to do extraordinary amounts of housework after their wives came home. One man routinely cooked breakfast for himself and three children, and then on his return from work cooked dinner for the entire family, bathed the children, and put them to bed. He did all this without question—that is, he did not ask his wife in words to resume her share of the household chores.

This lack of communication between husband and wife was a universal problem. Not only did the men find it hard to express any feeling toward their wives, other than mild irritation, but it was hard even to converse. At one point the group was enumerating various activities that husband and wife might do together to keep life interesting. After they had talked of sports, bridge, dancing and so on, one man said, ". . . but why do we always have to be doing something; why can't we just sit and talk?" Another man said, "It seems to be a failure of meeting of the male and female minds." That was as far as they went at the time, but four months later the group returned to the same topic at a somewhat more sophisticated level. They talked of their reluctance to confide their "secret thoughts," their fantasies and daydreams to their wives, or anyone else for that matter. They elaborated on their fear of ridicule, that they might be thought crazy. One man recognized a temptation to act on his fantasies, and was afraid his wife might perceive this temptation.

Communication between husband and wife was one thing that improved considerably during the project. The men felt encouraged to discuss some of these problems with their wives; it was not unusual for the men to go home from the meeting and

report the proceedings—and the wives were invariably curious. In this way they often were able to ventilate some gripes they might have been harboring for years. Both husbands and wives were pleased with the new freedom of speech, and the opinion was frequently repeated that "if we had only talked things over together like this before she got sick, she might never have had a breakdown."

One of the chief resistances to better insight was created by the very nature of this particular group, namely that the men's wives were psychotic. This was the inescapable reality, and understandably anxiety-provoking. It was hard for the men to see that this very real concern and anxiety was complicated and exaggerated by emotional disturbances within themselves. The therapist emphasized that there was little the group could do to help the wives directly; they were getting their own therapy. The men could make their best contribution by diminishing their own anxiety through the fullest expression and understanding of their own feelings.

Nevertheless there persisted a tendency to discuss the wife. This tendency was reinforced by the forceful, rigid personality of the army officer. From the beginning he took a firm stand that there was no problem in his marriage except that created by his wife's illness, that his own feelings and anxieties were irrelevant. Prior to his wife's illness theirs had been the perfect marriage, and all he wanted was a return to that normality.

The struggle between this man and the therapist for leadership of the group was nicely symbolized by some by-play that came about relative to the seating arrangements. The conference room contained a long rectangular table, at one end of which sat a large desk placed at right angle to the table. The seat behind the desk seemed too removed from the group, so at the first meeting the group leader sat at the free end of the table, close to the group, yet detached from it. When the therapist arrived for the third meeting, he found the officer in the seat behind the desk, manifestly the position of authority. The officer looked uneasy and explained that the armchair there was more comfortable. From this vantage point he further developed the role he had begun, that of chief interlocutor.

Characteristically he would begin the meeting by turning to another man: "Well, how's your wife getting along?" In this fashion he protected himself doubly. First he focused the discussion on the wives rather than on the men themselves. Secondly by encouraging others to talk he avoided talking about himself. When several attempts to interprete these defenses had failed utterly to alter the pattern, the therapist finally resorted to musical chairs. He arrived early and took the seat behind the desk. When the officer came, the group tittered and he wryly observed that the therapist had "stolen" his seat. He promptly took the seat at the free end of the table which the therapist had vacated, and continued to play his defensive role. The movement of the group toward more personal topics made his position less tenable; he gradually ceased directing the discussion toward the wives, and finally symbolized this change by sitting at the side of the table.

THE GROUP LEADER'S ROLE

The group-leader planned to remain as far as possible an observer and interpreter, but in the very first meeting this role was attacked by the group; and throughout there was a persistent effort to draw the leader into the discussion, to get corroboration and support. The therapist did try to answer questions of fact, about technical procedures or administrative rules. What happens in electric shock therapy; does it do any permanent damage? How long does the memory-loss last? Why do they treat some people with electric shock therapy and others with insulin? Do all patients go to Occupational Therapy? While the therapist replied directly to questions like these, at the same time he tried to get at the anxiety behind the question. The pronoun "they" was prominent: "Do they relapse? Do they recover their memories?"—and the therapist emphasized that though certain generalizations were possible, individual differences were usually of decisive importance.

Questions about psychotherapy were handled more carefully. The men were intensely curious as to what the wife said to her doctor. They sensed in their wives a considerable hostility toward themselves, and were jealous of her therapist. They made jokes about how she tells such and such to her doctor, but "she's damned if she'll tell me." There was some feeling, particularly in the early meetings, that the group leader, the clinic, and the wife's therapist were all in league against the husband, blaming him for her illness. These jealousies and resentments were never expressed directly, and attempts to bring them out in the open failed; but they seemed to diminish with time.

Questions about psychotherapy sometimes had another significance. One man asked whether psychotherapy could become a "crutch"; a friend, a social worker, warned him that often the patient became dependent on her psychiatrist for years, and he certainly did not want this to happen to his wife. After some discussion, another member wondered if the questioner was really talking about himself; maybe *he* was afraid of becoming too dependent on the group. The first man became quite tense and indignant; asked whether the therapist thought he was becoming too dependent on the group. Whether this was so or not, the therapist observed that he surely

was *afraid* of becoming too dependent. Although the leader tried to direct the discussion towards fear of dependence and its meaning, the problem was not worked through at the time. At the end of the meeting another member jokingly said to the anxious one: "I guess we won't see you next week; you'll have to prove that you can do without the group." In point of fact neither of these men showed up for the following session; and the man who was so upset stayed away three weeks. When he did return he was armed with some convincing excuses, and assured the group with chagrin that he had not tried to prove anything by his absence.

This fear of dependence was manifest in other ways. The men equated dependence with passivity, and vigorously resisted any hint of their passivity. On one occasion a man brought up his in-laws; described his father-in-law as a Caspar Milquetoast who is pushed around by his mother-in-law, a tough domineering woman. A second man, surprised, said, "Gee, you've just described my in-laws to a T." Several others agreed. They all said that such a relationship was anathema; they would choose divorce to being pushed around like that by their wives.

Divorce came up often but, interestingly, the men did not usually give it much consideration as a possible solution to their difficulties. It would be easy to consider this as evidence of guilt, but the therapist did not get the impression that such was the fact. Surely they were apprehensive about the social, financial, and personal consequences of divorce, but more important than these drawbacks seemed to be a fundamental need for their wives which led most of the men to want to work out their marriages positively, whatever the difficulties.

There was some serious talk about marriage as an institution. What should one expect from a husband or a wife in marriage? What is marriage for, why do people marry? Some men accepted unquestioningly the cultural stereotype of the happy marriage, and had tried to live up to it. With discussion they came to feel that this was unattainable and unrealistic, in part because it was a product of a bygone age. In the group they worked out their own somewhat more realistic ideal, although they recognized that certain exigencies might force them to compromise even with this.

Women, they agreed, should not be expected to do all the housework. Women work all day too, and a man should be willing to help with the evening chores until they are finished. The group agreed that there was nothing wrong with a woman's holding an outside job, if it would make her happy and contribute to the smooth running of the household. Some were not convinced and felt that woman's place is ideally in the home, unless it makes her "nervous."

In these discussions about who should do what, it became clear that breakfast has special significance for these men. Who should make breakfast had been a point of contention in many homes; in any marriage older than two years the point had been resolved and the husbands made their own breakfasts. On the rare occasions when a wife would prepare breakfast, the man interpreted it as a sign of favor, a gold star for good behavior. One man related the size of his breakfast to the satisfaction his wife had derived from sexual relations the night before, and this became a standing joke in the group.

Sexual topics were never explored very deeply, although the men agreed that sex was "important" to them and to marriage. Many of the wives, once they had become ill, said they had long been dissatisfied with their sexual experiences; and this came as a shock to their husbands. "I thought she enjoyed it as much as I did," one said. "After so many years, to find out she didn't—I can't really believe it. Maybe she just thinks so now." They never doubted their own sexuality; they spoke of how much they missed sexual relationships with their wives away, and it was tacitly assumed that each man was an adequate lover and that any sexual problems originated with their wives.

The chemist, in contrast to the others, stoutly maintained that sex was relatively unimportant since it was all in the mind, unlike hunger and thirst which were real physiological urges. This stand made the others quite angry. In general the chemist was inclined to rationalize, to express an unrelenting optimism which amounted to an outright denial of the very real problems that obviously beset him. Although the group was at first disconcerted by this Pollyanna, it gradually became clear that he was experiencing real difficulties and the group was reassured that one could not merely wish them away. The chemist was very irregular in his attendance and ultimately dropped out.

The husbands denied any interest in using other women to relieve these frustrations. No overt extramarital relationships were reported; on the contrary the men avowed great fidelity, although they generally admitted they were not unresponsive to the sight of a pretty girl. In this connection two men denounced their sisters-in-law for being irresponsible and wild. The group was a little puzzled as to why these women were "problems" for the men who talked about them so much; but not one brought up the possible temptations involved. Fidelity seemed to be a matter of contract rather than morality: "I would not like to see my wife unfaithful, so I shall

not be." The group was vehement about the wife's possible infidelity; they would throw her out. One man who disagreed was dismissed as a curiosity.

Subjects such as impotence, homosexuality, masturbation and perversion were never brought up; although in the preliminary interviews these topics had worried some members. All the men said their education in sexual matters during childhood had been painfully inadequate, but implied that this deficiency had been completely remedied. When the therapist questioned this assumption and suggested that perhaps they still had some questions, it did indeed provoke a lively discussion of contraception and other sexual topics.

Freedom of discussion was an issue throughout the meetings. At the end of the first session the group expressed a desire to structure the discussion by confining it to one man or one common problem at each meeting. Once, after a number of meetings had been held, the therapist called the group's attention to this pattern: three or four men would come a few minutes early and begin spontaneously to talk about sports, the weather, or a newspaper scandal. When the therapist arrived to start the meeting, they would lapse into silence, assume grim expressions and "begin" the meeting. They became indignant at this confrontation: "Well, what were they supposed to talk about, baseball?" When the therapist reminded them of their freedom to talk about anything at all, they said, "Yes, but we are here to talk about our problems with our wives and of course our own emotional problems; baseball would be a waste of time." Efforts to point out that whatever they talked about they were still expressing themselves were unavailing. There was a kind of masochistic determination to confess, no matter how painful. In the next session, a couple of men did begin to talk about their work, and thence developed a political debate; but everyone was uncomfortable about wandering from "problems."

After four months of meetings, a dramatic event occurred that threatened to disrupt the group: One of the members killed himself. He was a new member who had attended only two meetings. Neither in the preliminary interview nor in the meetings he attended did he give any indication of undue morbidity. At the first meeting he listened carefully; made a few rather pertinent comments. The next time he dominated the meeting; that is, his story occupied the principal part of the discussion. This was the usual pattern of behavior for new members, and his story was familiar. He shot himself through the head three days later, leaving a long note in which he said that he had intended visiting his wife the following day to kill her, but could not wait.

Two weeks later one of the members learned the story from the man's mother-in-law and told the group. The men were stunned at first and plied the informant with questions about the circumstances. They seemed anxious to identify him as a queer character, and to support this thesis they made much of the fact that he had lived in painful frugality although he had saved several thousand dollars. Then they began to feel sorry for his wife; she must have been set 'way back, they thought. But the man who knew the facts said: "Well, I saw her yesterday, and as a matter of fact I've never seen her looking better. My wife is on the same ward and says she is much better." (Indeed she improved rapidly and was discharged about three weeks later.) The men seemed reassured by this, as though to say maybe our wives' health is not so dependent on what we do as we had thought. It is interesting that they chose to ignore the other aspect of these events—the implication that if they would drop dead their wives might rapidly improve.

EVALUATION

It is difficult to assess the value of the group in helping its members or their wives. Both husbands and wives expressed satisfaction with the group meetings, but were relatively inarticulate as to just what they were pleased about. The men spoke of greater "confidence," less "nervousness," and increased ability to "talk things over" with their wives. The women made similar comments, but in addition seemed to benefit from the sharing of guilt that was implicit in the mere fact that their husbands came for therapy. All the women were discharged from the hospital "improved" during the period of the group meetings. Although it is true that not every hospitalized patient goes home, this fact proves little inasmuch as the women did not leave significantly sooner than the hospital average.

The group seemed to be particularly helpful to the men when their wives came home. Usually they had three or four weeks' warning, and there was a perceptible increase in anxiety. The man whose wife's discharge was imminent would bring up a host of questions; those members whose wives had already returned were helpful in reassuring him. The first two or three weeks after discharge were especially difficult. The husband whose wife had just come home usually dominated the sessions at this time, and was likely to be regular in his attendance. In the fourth and fifth week after discharge, there was a pronounced decrease in tension; the man would visibly "settle down."

Attendance was fairly regular. Although there was no particular pressure by the therapist for men to come, of a possible eight there were never fewer than four at a meeting—usually six or seven. The men continued after their wives had left the hospital, and some even after their wives stopped out-

patient therapy. The wives generally encouraged their husbands to come to the group; one man said the night of the meeting was the one night of the week he was sure to find dinner waiting for him when he got home.

Perhaps the most objective sign of change was the behavior of the men in the group situation. They became more expressive of feeling and more honest in their expressions. They talked more about themselves and less about their wives. These changes were dramatized by the advent of a new member. His anxieties, his fears, and his projections were reminders to the others of an age that had passed. Although the older members had voiced the same feelings in the initial meetings, they became somewhat supercilious and impatient. They were particularly adept in pointing out to the new man that what he considered to be his wife's problem was really his own projection. It was the kind of impatience that people who have achieved partial mastery of something that formerly gave them anxiety manifest toward those who are still struggling with the same problem.

The group had another value, economic. In most cases there was considerable reduction in the amount of time various staff members had to devote to the husband. Men who spent half an hour a week talking personally to their wife's therapist plus another fifteen minutes on the telephone, gave up this practice almost entirely. Nurses and social workers also noted that their contacts with the husbands were briefer and less frequent. That this was a real economy was attested by the comments of diverse staff members.

It is a psychiatric platitude that "environment" is an important etiologic factor in mental illness. A vacation, a divorce, a change of job or domicile—such recommendations at one time were the chief tools of psychiatry. With the advent of psychotherapy and somatic treatments, the accent fell on the individual patient and many therapists have paid less attention to the environment. Furthermore it became apparent that a disturbed person with a different spouse or job is still disturbed. Besides, more often than not the patient promptly places himself in the same kind of environment he has abandoned.

Yet "environment" is still important, and psychotherapy itself offers one of the best means of altering it, particularly in its most significant elements: The people with whom the patient has to live closely, day in and day out. If a therapist who spends an hour a week with a patient can, as we believe, exert a decisive influence for health or illness, how much more influential must those be who spend several hours with him every day? Group therapy with husbands, wives, parents and others close to the patient would seem to be an economical way to alter the patient's environment in the direction of health, and help those people who spend most time with him to a healthier adjustment.

Langley Porter Clinic.
The Medical Center.

Discussion by* ESTHER SOMERFELD-ZISKIND, M.D., *Los Angeles

The report presented here is of a fascinating experience such as only psychiatrists are permitted in their working hours. We owe Doctors Bowman and Gordon a debt of gratitude for having pointed the way to another therapeutic adjunct in schizophrenia.

It seemed to me, though, that the husbands of these psychotic women in treatment were not being frank with Dr. Gordon. The reason, I believe, was their sensing of Dr. Gordon's resentment of the husbands. After all, he gathered them in a group to save himself time because they represented a nuisance with their numerous calls. I wonder whether he would have gotten more frank expression from them as to their fears and their loyalties to their wives if he had told them why he gathered them together. Also they might have felt less guilty for their wives' illness if he had opened up the subject of their guilt without being too reassuring. They would have had a chance to defend themselves.

More of us should attempt experiments in group therapy.

General Anesthesia in Ophthalmology

GEORGE L. KILGORE, M.D., *San Diego*

• General or a combination of local and general anesthesia is beneficial in ophthalmic operations. With foreknowledge that they are to be asleep, patients approach operation with less trepidation, and during the procedure the surgeon can be more relaxed.

In a series of 300 cases reviewed, no complications that could be attributed to general anesthesia occurred at the operative site. Nasopharyngeal and tracheal irritation sometimes developed.

Anesthesia should be conducted by a well-trained, alert anesthetist; and the method and the agent should be determined after thorough examination and appraisal of the patient and consideration of the nature of the operation to be done.

ALMOST ALL PATIENTS confronted with the prospect of an operation upon the eyes have conscious or unconscious fear of pain and of what might happen if the eyes are moved during the procedure.

In an attempt to find a way to relieve this fear, the author in a series of ten cases of bilateral cataract extraction used local anesthesia for the removal of the cataract from one eye, then for the operation on the other eye used a combination of the same local anesthesia and Pentothal® sodium intravenously. All the patients, without being questioned, remarked upon the ease (to themselves) of the second operation. None had known when the operation was done, and all spoke particularly of the absence of disturbing flashes of light. They also remarked that they were free of the mental task of holding the eyes still. All wanted to know why the first operation had not been done under general anesthesia.

Knowing these benefits, a surgeon intending to use general anesthesia can give reassurance to patients before operation. Moreover, the surgeon himself can be more relaxed while carrying out an intraocular operation if the patient is asleep.

All patients should have a general physical examination before general anesthesia is given, in order that the anesthetist may select the most appropriate agent. When operation must be done in emergency, circumstances are of course variable and special evaluation is necessary. Patients who are to undergo elective operation not only should have a study of their general condition, but any system disorders like diabetes should be under control. The author does not hesitate to call upon a general practitioner or internist for help when diabetes, extremely high blood pressure or other such complicating conditions are present.

When such precautions are taken, there are very few patients for whom general anesthesia is unsuitable. Selection of the anesthetic agent, which should be discussed with the anesthetist, must take into account the general condition of the patient, the operation to be done and the time required for it. An occasional patient will, when asked, give a history of having had a reaction to procaine or other anesthetic agent in the past. It is important to ask, and important to avoid use of any agent indicted by the patient's reply.

Very old and very young persons are not well suited to Pentothal anesthesia. For them it is far better to use other agents. Of course ether has a wide margin of safety in children, but the possibility of postoperative vomiting must be considered in relation to what damage it might do to the surgical repair.

It is essential that expert anesthetists be in attendance in all cases of young children, doubly so if the patient has a congenital defect of the heart.

All patients, children and adults, who are to have general anesthesia during an ocular operation, should have an intratracheal tube in place before operation is begun. Either of two types of tube may be used: One has a cuff encircling it and is inflated to fill the trachea completely, and the other is used with a fairly tight fit between the tube and the vocal cords. One patient operated upon by the author died during anesthesia; and although he was a very small, frail child, one must wonder whether the covering over his face and the lack of unobstructed oxygen flow did not in some way contribute to the emergency.

The advent of Pentothal sodium as an intravenous agent stimulated the use of general anesthesia for operations upon the eye. The history of the development and use of Pentothal and morphine as anesthetic agents are satisfactorily summarized and dis-

Presented before the Section on Eye, Ear, Nose and Throat at the 81st Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1952.

cussed in a number of articles that have appeared during the last few years.[1, 2, 3, 4, 6] In these articles attention has been drawn to the depressor effect of Pentothal, especially on the centers governing respiration and blood pressure. Warning is given as to the poor tolerance by very young and very old persons.

Attention has been drawn to the need of auxiliary medication, such as atropine, to prevent bronchospasm and laryngospasm during the use of Pentothal. Linn[5] stated that nausea and vomiting occurred in 4 per cent of patients observed by him. He intimated that these complications were probably due as much to preoperative medications as to Pentothal. He reported one death during Pentothal anesthesia. At autopsy the patient was found to have nephritis, hypertension, chronic hepatitis and cholecystitis.

The use of morphine intravenously for patients undergoing ocular operations has been recommended. Jensen, Haffley and Sarro,[4] although calling attention to the constant reminders that this anesthetic drug is very dangerous, maintained that allergic forms of bronchial asthma are the only contraindication to its use.

Paralysis of the extraocular muscles following general anesthesia has been reported, but the operations were not on or around the eyes.

In the author's experience since 1934, the combination of local and general anesthesia for ocular operations has been very satisfactory. Intraocular operations are well suited to a combination of the local use of cocaine and/or Pontocaine® drops and intravenous use of Pentothal, or a combination of Pentothal intravenously and a small amount of nitrous oxide, gas and oxygen. The latter combination of agents serves well in cases of cataract extraction in children. Postoperative nausea and vomiting are reduced to a minimum.

For extraocular operative procedures the patient can be given ether or a combination of agents for anesthesia since postoperative nausea and vomiting are not a serious consideration.

What complications attributable to the anesthetic arise during operations? The most disturbing is nausea and vomiting in children who are receiving ether and oxygen or a combination of ether and other agents. An accident of this type is directly attributable to lack of experience or lack of attention on the part of the anesthetist. Redraping is necessary when vomitus soils the field of operation. Coughing or labored breathing are disturbing during intraocular operations. Anesthetists now use a small amount of curare derivative (tubocurarine or Flaxedil) intravenously for the relaxation of the laryngeal and tracheal muscles.

Coughing and laryngospasm are two complications that have done much to prevent wider use of general anesthesia (Pentothal) for patients undergoing intraocular operations. These complications can be prevented by the use of atropine preoperatively and the use of added anesthetic agents just before removing the tracheal tube and sucking mucus from the throat.

The use of general anesthesia in the office depends upon the common practice in the community and on the nature of the procedure to be carried out. The author uses ether as an anesthetic when making examinations of difficult children and when probing tear ducts. The anesthetic is given in the morning and the patient is not permitted to have food or liquids after 6 o'clock the preceding evening. The local use of Pontocaine or cocaine solution helps to lessen the amount of anesthetic necessary for examinations of the eyes. It is imperative to have a suction device, in working order, on hand at the time the anesthetic is given.

The following observations were made in a review of records of 300 operations performed under a combination of local and general anesthesia:

1. There was no prolapse of the iris, loss of vitreous, rupture of the incision or any other accident which could be attributed to use of general anesthesia.

2. Laryngeal and bronchial irritation developed in a few cases. Irritation of the nasal membranes and the nasopharynx often developed after the use of a nasopharyngeal tube during anesthesia. (The author does not recommend use of a nasopharyngeal tube.)

3. Plaques developed on the vocal cords of one patient following the use of a tracheal tube. The use of Zephiran® as a sterilizing agent was thought to be the cause of irritation. A too tightly fitting intratracheal tube could contribute to such complications.

4. There were no cases of thrombophlebitis following the use of Pentothal.

5. The time of operation varied from ten minutes for a discission to two hours and thirty-five minutes required for repair of orbital and facial disfigurement.

3315 Fourth Avenue.

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CASE REPORTS

• Melanoma of the Rectum

Melanoma of the Rectum

RODERICK M. NEALE, M.D., and
JOHN D. BRIGGS, M.D., *Los Angeles*

In 1857 Moore[4] reported upon a 65-year-old man with recurrent melanoma of the rectum treated initially by local excision. This appears to be the first description of melanoma in this location in man, although rectal melanotic tumors had been frequently noted in certain strains of horses. By 1949 there were in the literature reports of 94 cases of melanoma of the anus.[6] Pack and Livingston[6] stated that 2 per cent of all melanomas in human beings are located in this area.

In the following case a melanoma appeared first at the mucocutaneous junction of the anal canal, and recurred on two occasions at successively higher levels under the rectal mucosa.

CASE REPORT

A 51-year-old white man was admitted to Wadsworth Hospital on May 2, 1951, because of a recurrent lesion of the rectum. The tumor had been first discovered in June 1949 following passage of several blood-streaked stools. At that time it was 2.5 centimeters in diameter and was treated elsewhere by local excision followed by x-ray therapy. In April 1950 recurrence at the original site was noted and removed. A year later there was a second recurrence and the patient was referred to Wadsworth Hospital for radical excision of the rectum.

The patient had had no symptoms referable to the rectum, other than the previously noted blood-streaked stools. In the family history the only pertinent factor was that the maternal grandmother died of carcinoma of the tongue at the age of 94.

The patient was moderately obese. Just inside the mucocutaneous junction of the rectum was a raised black lesion 1 cm. in diameter. The nodule was freely movable with the mucosa over the deeper layers and was quite firm. There was no enlargement of inguinal nodes. The liver was not palpable.

The microscopic sections from the previous surgical excisions were reviewed and the diagnosis of melanoma was confirmed.

Sigmoidoscopic examination of the lower bowel was carried out but the previously described black nodule in the anal canal was the only abnormality observed.

On May 18, 1951, abdominoperineal resection of the rectum was performed. No evidence of metastatic involvement of either the liver or lymph nodes adjacent to the lower colon was found. The postoperative course was uneventful.

Upon gross pathologic examination the specimen was observed to contain a nodule 3 cm. above the external sphincter (Figure 1). The nodule was 1 cm. in diameter and 0.5 cm. thick. It was blue-brown in color, slightly ulcerated on its superior surface and did not extend through the submucosa. Microscopically the tumor was found to consist of large cells containing melanin (Figure 2). Extension to the lymph nodes was not found.

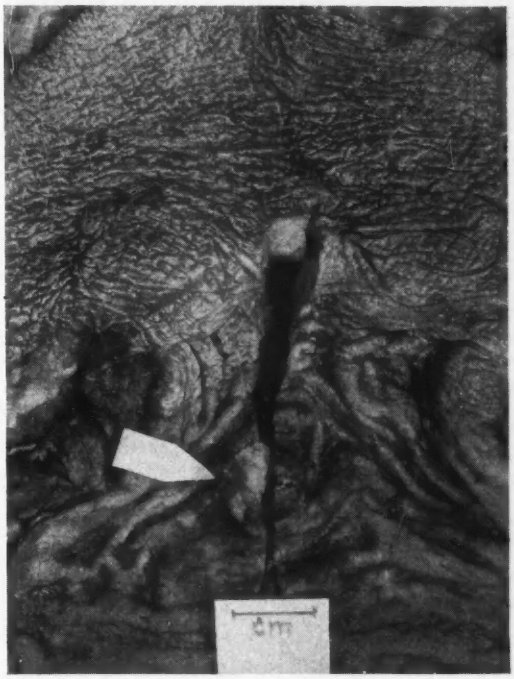

Figure 1.—Melanoma of rectum located 3 cm. above mucocutaneous junction. The cut surface shows pigmentation.

The patient was last observed April 28, 1952, and no evidence was found of either local or distant recurrence.

DISCUSSION

Dawson[2] reported in detail studies which concluded that "melanin pigmented tumors are regarded as having their origin in epidermal or neuroepithelial cells and melanin pigment formation in the body is regarded as exclusively an ectodermal function." Willis,[7] however, expressed belief that melanomas may be formed from mesodermal, ectodermal, or neuroepithelial cells which happen to contain melanin.

Further difference of opinion exists in the literature as to whether melanomas arise primarily in the gastrointestinal tract, or are secondary to lesions in the skin, eye, or central nervous system. Willis, in discussing melanomas of the

From the Surgical Service, Wadsworth Hospital, Veterans Administration Center, and the Department of Surgery, University of California, Los Angeles.

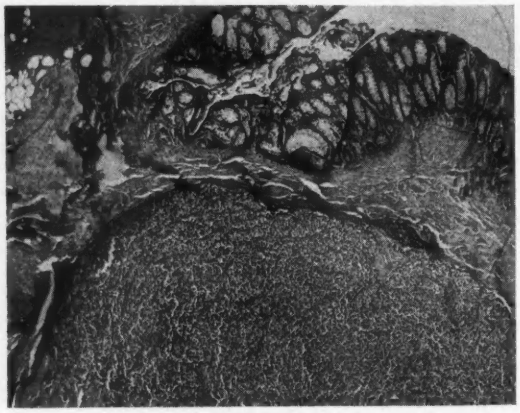

Figure 2.—The melanoma is submucosal, being covered with normal rectal mucosa.

gastrointestinal tract, stated: "In such cases, unless meticulous search of every part of the skin, eyes and juxtacutaneous mucous membranes proves the absence of a possible primary growth there and inquiry elicits positive certainty that the patient has never had any skin lesions which might have been the primary source—the primary visceral origin of a melanoma cannot be accepted. I know of no reported cases fully satisfying these strict requirements." Herbut and Manges[3] also stated the opinion that melanomas do not originate as primary lesions of the gastrointestinal tract. They pointed out that melanoblasts have not been demonstrated in the small intestine and that primary and secondary growths have similar histological patterns. They noted also that since 25 years or more may elapse before the appearance of the metastatic tumor, the original lesion may well have been forgotten.

Confusion has arisen in the reporting of cases of melanoma of the rectum owing to the use of conflicting terms and authors neglecting to state whether or not the growth was considered to be primary in the bowel. Braastad, Dockerty and Dixon[1] stated that melano-epitheliomas of the anus and rectum arise from melanoblasts of the anal epithelium and that submucosal spread upward accounts for rectal growths. The conditions observed in the case herein reported support this view.

The recurrence of the lesion after local excision also indicates that initial radical treatment is required in dealing with malignant growth of this type.

6226 West Manchester Boulevard.

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EDITORIAL

The Department of Health, Education and Welfare

AMERICAN MEDICINE reached the high point of its relations to government at 10:30 a.m. on March 14, 1953, when a special session of the House of Delegates of the American Medical Association was addressed by the President of the United States, Dwight D. Eisenhower. This fourth special session of the House in the 104-year history of the A.M.A. met in Washington, D. C., to consider what action should be taken with reference to Reorganization Plan No. 1 of 1953 to create a Department of Health, Education and Welfare. For almost 80 years and as recently as December 1952 the House has taken a stand for a Department of Health with cabinet status in the Federal Government.

Details of the reorganization plan published elsewhere in CALIFORNIA MEDICINE provide not for a Department of Health but for a Department of Health, Education and Welfare—this to be accomplished by elevation and reorganization of the Federal Security Administration to make of it a department with cabinet rank. Because this proposed plan was not in keeping with the time-honored stand of the A.M.A., because the A.M.A. previously had opposed establishment of such a department during the Truman Administration and because the final decision had to be made before June, the Board of Trustees of the association wisely felt that the decision should be made by the House of Delegates and that a special session of it was necessary.

Many physicians and leaders in the A.M.A. had been opposed to the linking together of Health, Education and Welfare in government. This has been owing chiefly to the questionable need for, the large size of, the doubtful practices of, and the socialistic trends of the Social Security System. There has been potent opposition to the health activities of the government being attached as the small tail on so large, so unfriendly and so unwanted a dog. Furthermore, in the long time view, once such a relationship is established it tends to stick and future administrations less friendly to medicine might find it an excellent situation for a quick grasp to establish socialized, federalized or compulsory medical care.

The present administration including the President, and the Federal Security Administrator, Mrs. Oveta Culp Hobby, has been friendly toward the medical profession. As the President said in his address before the House, his philosophy was such that he was for free enterprise, that he pledged opposition to compulsory and socialized medicine and that he would not make government a "big poobah" of medical affairs. Senator Taft, the majority leader of the Senate, pointed out that the reorganization plan would without question become the law, that the only reason for grouping health, education and welfare was that they were secondary functions of the government, that establishing the F.S.A. as a department would bring it in closer and beneficial contact with the President and other departments of the government which would not be attained while it remained an independent agency, that the functions of the department would be studied by a new commission to be appointed by the President and Congress and that one of the major purposes of the reorganization was to get rid of the influence of F.S.A. policy-makers now protected under Civil Service. In fact the implication was that this was the

only way in which some of the staff members of F.S.A. so well known for their desires to socialize medicine could be eliminated from policy-making jobs in the Department. Congressman Walter Judd (Republican, Minnesota), a well-known physician, urged physicians not again to say, "We're against it," and added that "Stalin may be tough, but I don't think there is anything stronger than entrenched bueaucracy."

With this consideration in mind and with assurance that health was to be given a special position not as a separate bureaucratic sub-department but by establishment of a special assistant to the Secretary who is to be a recognized leader in the medical field with a wide non-governmental experience to review for and advise the Secretary, the House of Delegates approved the report of the Board of Trustees. The report supports the reorganization plan, indicates that it is a step in the right direction, urges that the A.M.A. cooperate to make it successful, suggests that the development of the plan be watched with great care and interest and notes that the "association reserves the right to make recommendations for amendments in the then existing law if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control."

For too many years the medical profession and the A.M.A. have been accused of being against almost every step and for nothing constructive. For us as a profession, but not as individuals, public relations have not been good. Now there is an opportunity for us to become the leaders, to see what we can do when given the opportunity for at least four years under a friendly administration to establish the proper relations between government and medicine, to develop that kind of health service in government which long has been needed and to consider carefully the proper relations of the public health aspects of medicine, the medical profession and the private practice of medical care.

LETTERS to the Editor . . .

Rectal Curarization

DELAY AND THUILLIER* of the Faculty of Medicine, Paris, report the successful curarization of rabbits by means of rectal suppositories. Rectal curarization of rabbits follows a definite pattern. First, the ears drop, then there is a softening of the muscles of the neck, then the head drops, and finally there is complete quadriplegia. In case of an overdose this is followed by paralysis of the diaphragm, cessation of breathing, and death. Intravenous injection of 0.25 mg. of physostigmine will stop the curarization at will at any time or in case of an overdose.

With suppositories containing 0.5 mg. of D-tubocurarine per milligram of body weight curarization of rabbits takes four to six minutes to develop and lasts three to five hours. Similar results were subsequently obtained with neurological and psychiatric patients.

W. H. MANWARING, M.D.
Palo Alto, Calif.

* Delay, J., and Thuillier, J. E., Curarization by rectal suppository, Science, 117:57, Jan. 16, 1953.

California MEDICAL ASSOCIATION

NOTICES & REPORTS

The U. S. Department of Health, Education and Welfare

• DR. LOUIS H. BAUER'S LETTER TO THE MEMBERS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

March 5, 1953

I HAVE BEEN REQUESTED to write each member of the House of Delegates a letter so as to bring him up to date on what has transpired since the December meeting of the House.

In December a request was sent to Mrs. Oveta Culp Hobby, the proposed new Federal Security Administrator, for a conference. This conference was finally arranged for February 3, 1953. Attending it were Drs. Bauer, McCormick, Murray, Blasingame, Lull, Howard and Wilson. Our group received a most cordial welcome. General matters pertaining to the Federal Security Agency were explored and ideas exchanged. Mrs. Hobby was asked if she would like to have a committee from the American Medical Association to which she could turn for assistance and cooperation. She replied that she would and asked that we appoint such a committee. It was quite evident, throughout the conference, that cooperation and mutual exchange of ideas would be the order of the day from then on.

Our group left then with the distinct feeling that the door to the Federal Security Agency is wide open to the American Medical Association.

The Board of Trustees later designated the following committee to be of assistance to the Federal Security Agency: Drs. E. L. Henderson, chairman; L. H. Bauer, vice-chairman; Edward J. McCormick, Dwight H. Murray, and F. J. L. Blasingame. Dr. Walter B. Martin was named as an alternate member.

The following day, February 5, Drs. Bauer, McCormick, Murray and Wilson had an opportunity to talk to the President. He, too, was most cordial and a broad discussion of various problems took place. Although our appointment was for thirty minutes, we were there forty-five minutes. We left there, all feeling that medicine has a "friend at court."

The public announcement that the Federal Security Agency is to be raised to the status of an executive department naturally is of great interest to us. I had further correspondence and telephone conversations with Mrs. Hobby and a telephone conversation with the President. As a result of these Dr. Blasingame and I met with the Rockefeller Reorganization Committee on February 18. A general discussion on the medical aspects of the reorganization took place. Following that, I had further telephone conversations with Mr. Rockefeller, and as a result another conference was held with this committee. Those attending from the American Medical Association were Drs. Bauer, McCormick, Murray, Martin, Blasingame, McCarthy, Lull, Howard, and Wilson, and Mr. Steler. This conference took place on February 25.

Some of the officers of the American Medical Association in the meantime had conferred with members of Congress, particularly Senator Taft.

We had been informed that an independent Department of Health or Health Agency would not be proposed. There is a feeling in the administration and in Congress that there are already too many independent agencies and that attempts should be made to reduce rather than expand the number.

It is proposed to change the Federal Security Agency to the Department of Health, Education and Social Security. It will not be departmentalized, but in the Secretary's office there will be a Special Assistant, to the Secretary, for Health and Medical Affairs. All matters pertaining in any way to health or medicine, no matter where in the Department they originate, will have to be cleared through this Special Assistant to the Secretary. In other words, this official will be in charge, under the Secretary, of all health and medical matters in the Department. In addition, this same official will be the representative of the Secretary in all interdepartmental meetings when health is to be discussed, and at all international health meetings. He will also be the Secre-

tary's representative at congressional hearings on health matters pertaining to the Department.

The qualification for the position will be specified as a Doctor of Medicine from non-governmental sources. He will also be the contact between the Department and the American Medical Association, the American Dental Association, the American Hospital Association, the American Public Health Association, and the State and Territorial Health Officers Association.

Details of the reorganization plan, copies of the President's message submitting it and other information have been promised to us for the Special Session of the House on March 14, so that each delegate may have everything in front of him.

The House of Delegates has gone on record several times as desiring a separate Department of Health. Since this proposed plan does not provide for that, but for a plan not heretofore considered, the Board of Trustees did not feel it could take any action, but that the House of Delegates itself should consider the matter and decide what action should be taken by the Association.

Since the matter will in all probability be settled prior to June, it was necessary to call a special session of the House.

LOUIS H. BAUER, M.D.,
President, American Medical Association

* * *

Reorganization Plan No. 1 of 1953

Prepared by the President and transmitted to the Senate and the House of Representatives in Congress assembled, March 12, 1953, pursuant to the provisions of the Reorganization Act of 1949, approved June 20, 1949, as amended.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Section 1. *Creation of Department: Secretary.*—There is hereby established an executive department, which shall be known as the Department of Health, Education, and Welfare (hereafter in this reorganization plan referred to as the Department). There shall be at the head of the Department a Secretary of Health, Education, and Welfare (hereafter in this reorganization plan referred to as the Secretary), who shall be appointed by the President by and with the advice and consent of the Senate, and who shall receive compensation at the rate now or hereafter prescribed by law for the heads of executive departments. The Department shall be administered under the supervision and direction of the Secretary.

Sec. 2. *Under Secretary and Assistant Secretaries.* There shall be in the Department an Under Secretary of Health, Education, and Welfare and two Assistant Secretaries of Health, Education, and Welfare, each of whom shall be appointed by the President by and with the advice and consent of the Senate, shall perform such functions as the Secretary may prescribe, and shall receive compensation at the rate now or hereafter provided by law for under secretaries and assistant secretaries, respectively, of executive departments. The Under Secretary (or, during the absence or disability of the Under Secretary or in the event of a vacancy in the office of Under Secretary, an Assistant Secretary determined according to such order as the Secretary shall prescribe) shall act as Secretary during the absence or disability of the Secretary or in the event of a vacancy in the office of Secretary.

Sec. 3. *Special Assistant.*—There shall be in the Department a Special Assistant to the Secretary (Health and Medical Affairs) who shall be appointed by the President by and with the advice and consent of the Senate from among persons who are recognized leaders in the medical field with wide non-governmental experience, shall review the health and medical programs of the Department and advise the Secretary with respect to the improvement of such programs and with respect to necessary legislation in the health and medical fields, and shall receive compensation at the rate now or hereafter provided by law for assistant secretaries of executive departments.

Sec. 4. *Commissioner of Social Security.*—There shall be in the Department a Commissioner of Social Security who shall be appointed by the President by and with the advice and consent of the Senate, shall perform such functions concerning social security and public welfare as the Secretary may prescribe, and shall receive compensation at the rate now or hereafter fixed by law for Grade GS-18 of the general schedule established by the Classification Act of 1949, as amended.

Sec. 5. *Transfers to the Department.*—All functions of the Federal Security Administrator are hereby transferred to the Secretary. All agencies of the Federal Security Agency, together with their respective functions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds (available or to be made available), and all other functions, personnel, property, records, and unexpended balances of appropriations, allocations, and other funds (available or to be made available) of the Federal Security Agency are hereby transferred to the Department.

Sec. 6. *Performance of Functions of the Secretary.* The Secretary may from time to time make such provisions as the Secretary deems appropriate authorizing the performance of any of the functions of the Secretary by any other officer, or by any agency or employee, of the Department.

Sec. 7. *Administrative Services.*—In the interest

of economy and efficiency the Secretary may from time to time establish central administrative services in the fields of procurement, budgeting, accounting, personnel, library, legal, and other services and activities common to the several agencies of the Department; and the Secretary may effect such transfers within the Department of the personnel employed, the property and records used or held, and the funds available for use in connection with such administrative service activities as the Secretary may deem necessary for the conduct of any services so established: *Provided*, That no professional or substantive function vested by law in any officer shall be removed from the jurisdiction of such officer under this section.

Sec. 8. *Abolitions.*—The Federal Security Agency (exclusive of the agencies thereof transferred by section 5 of this reorganization plan), the offices of Federal Security Administrator and Assistant Federal Security Administrator created by Reorganization Plan No. 1 (53 Stat. 1423), the two offices of assistant heads of the Federal Security Agency created by Reorganization Plan No. 2 of 1946 (60 Stat. 1095), and the office of Commissioner for Social Security created by section 701 of the Social Security Act, as amended (64 Stat. 558), are hereby abolished. The Secretary shall make such provisions as may be necessary in order to wind up any outstanding affairs of the Agency and offices abolished by this section which are not otherwise provided for in this reorganization plan.

Sec. 9. *Interim Provisions.*—The President may authorize the persons who immediately prior to the time this reorganization plan takes effect occupy the offices of Federal Security Administrator, Assistant Federal Security Administrator, assistant heads of the Federal Security Agency, and Commissioner for Social Security to act as Secretary, Under Secretary, and Assistant Secretaries of Health, Education, and Welfare and as Commissioner of Social Security, respectively, until those offices are filled by appointment in the manner provided by sections 1, 2, and 4 of this reorganization plan, but not for a period of more than 60 days. While so acting, such persons shall receive compensation at the rates provided by this reorganization plan for the offices the functions of which they perform.

* * *

Position Description

Special Assistant to the Secretary (Health and Medical Affairs), Department of Health, Education and Welfare

The Special Assistant to the Secretary will be the top staff policy adviser to the Secretary with respect to health and medical matters. He will have responsibility for reviewing the health and medical programs throughout the Agency and, where necessary, making recommendations for improvement. On matters of legislative policy where health and medical policies are involved, he will be responsible for making recommendations to the Secretary. This will include review of legislative reports involving health and medical care matters, proposed testimony before congressional committees relating to health and medical care matters, and other related policy statements such as annual reports, etc.

As chief staff policy adviser in the health and medical field, the Special Assistant to the Secretary will represent the Secretary on top level interdepartmental committees concerned with health and medical care matters, such as the Health Resources Advisory Committee to the President. He will have responsibility for liaison on behalf of the Secretary with important non-governmental groups, such as the American Medical Association, the American Dental Association, the American Hospital Association, the American Public Health Association, and the Association of State and Territorial Health Officers. Such liaison will not, of course, supplant liaison by the constituents of the Department but would be broadly representative of the total interests of the Department in the health field. He will, when appropriate, represent the Secretary in making speeches before various groups interested in health and medical problems faced by the Federal Government and particularly by the Department of Health, Education and Welfare.

The Special Assistant to the Secretary will, from time to time, represent the Secretary at various international meetings, such as being a delegate to the World Health Assembly of the World Health Organization, and other major international assignments. Such representation will not, of course, supplant appropriate representation from the Public Health Service, the Children's Bureau and other constituents of the department. The new Department of Health, Education and Welfare will continue to have major and numerous international responsibilities in the field of health as a positive arm of U. S. foreign policy.

As directed by the Secretary, the Special Assistant to the Secretary will see that related health and medical problems arising in any of the various constituents having health or medical care programs are properly coordinated. These constituents are: the Public Health Service, the Social Security Administration (including the Children's Bureau), the Food and Drug Administration, the Office of Vocational Rehabilitation and St. Elizabeth's Hospital. Coordination between related activities of these constituents is a matter of very substantial importance.

In short, the Special Assistant to the Secretary will be the top staff policy adviser to the Secretary on health and medical matters, will represent the

Secretary in important external relationships of the department with national and international bodies concerned with health and medical matters, and will, as needed, coordinate related health and medical programs within the department.

* * *

Letter of Transmittal

To the Congress of the United States:

I transmit herewith Reorganization Plan No. 1 of 1953, prepared in accordance with the provisions of the Reorganization Act of 1949, as amended.

In my message of February 2, 1953, I stated that I would send to the Congress a reorganization plan defining a new administrative status for Federal activities in health, education, and social security. This plan carries out that intention by creating a Department of Health, Education, and Welfare as one of the executive departments of the government and by transferring to it the various units of the Federal Security Agency. The department will be headed by a Secretary of Health, Education, and Welfare, who will be assisted by an Under Secretary and two assistant secretaries.

The purpose of this plan is to improve the administration of the vital health, education, and social security functions now being carried on in the Federal Security Agency by giving them departmental rank. Such action is demanded by the importance and magnitude of these functions, which affect the well-being of millions of our citizens. The programs carried on by the Public Health Service include, for example, the conduct and promotion of research into the prevention and cure of such dangerous ailments as cancer and heart disease. The Public Health Service also administers payments to the states for the support of their health services and for urgently needed hospital construction. The Office of Education collects, analyzes and distributes to school administrators throughout the country information relating to the organization and management of educational systems. Among its other functions is the provision of financial help to school districts burdened by activities of the United States Government. State assistance to the aged, the blind, the totally disabled, and dependent children is heavily supported by grants-in-aid administered through the Social Security Administration. The old age and survivors insurance system and child development and welfare programs are additional responsibilities of that administration. Other offices of the Federal Security Agency are responsible for the conduct of Federal vocational rehabilitation programs and for the enforcement of food and drug laws.

There should be an unremitting effort to improve those health, education and social security programs which have proved their value. I have already recommended the expansion of the social security system to cover persons not now protected, the continuation of assistance to school districts whose population has been greatly increased by the expansion of defense activities, and the strengthening of our food and drug laws.

But good intent and high purpose are not enough; all such programs depend for their success upon efficient, responsible administration. I have recently taken action to assure that the Federal Security Administrator's views are given proper consideration in executive councils by inviting her to attend meetings of the Cabinet. Now the establishment of the new department provided for in Reorganization Plan No. 1 of 1953 will give the needed additional assurance that these matters will receive the full consideration they deserve in the whole operation of the government.

This need has long been recognized. In 1923, President Harding proposed a Department of Education and Welfare, which was also to include health functions. In 1924, the Joint Committee on Reorganization recommended a new department similar to that suggested by President Harding. In 1932, one of President Hoover's reorganization proposals called for the concentration of health, education and recreational activities in a single executive department. The President's Committee on Administrative Management in 1937 recommended the placing of health, education and social security functions in a Department of Social Welfare. This recommendation was partially implemented in 1939 by the creation of the Federal Security Agency—by which action the Congress indicated its approval of the grouping of these functions in a single agency. A new department could not be proposed at that time because the Reorganization Act of 1939 prohibited the creation of additional executive departments. In 1949, the Commission on Organization of the Executive Branch of the Government proposed the creation of a department for social security and education.

The present plan will make it possible to give the officials directing the department titles indicative of their responsibilities and salaries comparable to those received by their counterparts in other executive departments. As the Under Secretary of an executive department, the Secretary's principal assistant will be better equipped to give leadership in the department's organization and management activities, for which he will be primarily responsible. The plan opens the way to further administrative improvement by authorizing the Secretary to centralize services and activities common to the several agencies of the department. It also establishes a uniform method of appointment for the heads of the three major constituent agencies. At present, the Surgeon General and the Commissioner of Education are ap-

pointed by the President and confirmed by the Senate, while the Commissioner for Social Security is appointed by the Federal Security Administrator. Hereafter, all three will be Presidential appointees subject to Senate confirmation.

I believe, and this plan reflects my conviction, that these several fields of Federal activity should continue within the framework of a single department. The plan at the same time assures that the Office of Education and the Public Health Service retain the professional and substantive responsibilities vested by law in those agencies or in their heads. The Surgeon General, the Commissioner of Education and the Commissioner of Social Security will all have direct access to the Secretary.

There should be in the department an Advisory Committee on Education, made up of persons chosen by the Secretary from outside the Federal Government, which would advise the Secretary with respect to the educational programs of the department. I recommend the enactment of legislation authorizing the defrayal of the expenses of this committee. The creation of such a committee as an advisory body to the Secretary will help ensure the maintenance of responsibility for the public educational system in state and local governments while preserving the national interest in education through appropriate federal action.

After investigation I have found and hereby declare that each reorganization included in Reorganization Plan No. 1 of 1953 is necessary to accomplish one or more of the purposes set forth in section 2(a) of the Reorganization Act of 1949, as amended. I have also found and hereby declare that by reason of these reorganizations, it is necessary to include in the reorganization plan provisions for the appointment and compensation of the new officers specified in sections 1, 2, 3, and 4 of the reorganization plan. The rates of compensation fixed for these officers are, respectively, those which I have found to prevail in respect of comparable officers in the executive branch of the government.

Although the effecting of the reorganizations provided for in the reorganization plan will not in itself result in immediate savings, the improvement achieved in administration will in the future allow the performance of necessary services at greater savings than present operations would permit. An itemization of these savings in advance of actual experience is not practicable.

DWIGHT D. EISENHOWER

The White House, March 12, 1953.

Report of A.M.A. Board of Trustees

Presented by Dwight H. Murray, M.D., Chairman, March 14, 1953

The House of Delegates of the American Medical Association has for nearly 80 years been on record as favoring an independent Department of Health in the Federal government. The reason for this stand has been that the House has felt that health and medicine should be given a status commensurate with their dignity and importance in the lives of the American people, and that they should be completely divorced from any political considerations.

The Board of Trustees, after a careful study of the policy of the American Medical Association with respect to the administration of health activities in the Executive Branch of the government and after studying the Reorganization Plan for elevation of the Federal Security Agency to Cabinet status submitted by President Eisenhower to the Congress, finds that Reorganization Plan No. 1 of 1953 provides for a Special Assistant, to the Secretary, for Health and Medical Affairs. This provision is a step in the right direction which should result in centralized coordination under a leader in the medical field of the health activities of the proposed department. Health, therefore, is given a special position. The proposed plan, properly administered, will permit more effective coordination and administration of the health activities of the new department without interference or control by other branches.

Previous attempts to raise the Federal Security Agency from an independent agency to the level of an Executive Department have been opposed by the Association because the plan did not meet these aims.

Inasmuch as Federal health benefits and programs are established by the Congress, an administration bent on achieving the nationalization of medicine cannot reach that goal except with the support of Congress. Therefore, an organizational plan through which Federal health activities are administered, although important, is not nearly so vital an issue as the policies adopted by the Congress.

The Board of Trustees recommends that the House of Delegates reaffirm its stand in favor of an independent Department of Health but that it support the Reorganization Plan No. 1 of 1953 as being a step in the right direction; that the American Medical Association cooperate in making the plan successful and that it watch its development with great care and interest.

It should be understood, however, that the Association reserves the right to make recommendations for amendment of the then existing law and to continue to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control.

The Treatment of Cancer with "Laetriles"

A Report by the Cancer Commission of the California Medical Association

THE INFORMATION that a new agent designated as Laetrile was being advocated for the treatment of cancer first came to the officers of the Cancer Commission of the California Medical Association in the form of inquiries from a number of magazines with national circulation in September 1952. Within the next several weeks following these original inquiries, information was sought by representatives of the major news services and by a majority of the metropolitan daily newspapers in California, usually through the science editors of these newspapers. In one instance we are informed a list of patients was given to a newspaper by a physician, who invited the representative of the newspaper to interview and photograph the patients at their homes as examples of the dramatic results of Laetrile treatment. The need for a thorough study of the claims which were being made finally became apparent when a member of the attending staff of the Los Angeles County Hospital requested permission for the investigational use of Laetrile in cancer in that institution. The request was originally presented to the tumor board of the Los Angeles County Hospital and was denied, but subsequently limited permission for the trial use of Laetrile in the hospital, upon patients informed and assenting, was obtained through another committee of the hospital.

1. *Nature of the treatment method.* Laetrile is supposed to affect malignant neoplasms by "focally triggering off lethal quantities of nascent hydrogen cyanide." The term Laetrile is derived from the fact that the chemical is a laevo-rotary-nitrile. It is claimed that this type of therapy was first used in human cancer by Ernst T. Krebs, Sr., shortly after 1920, when "substantial clinical results" were obtained from the use of a beta-cyanogenetic glucoside named amygdalin. Amygdalin is readily obtained as an extract of apricot pits.

The claim made during 1952 by Mr. Ernst T. Krebs, Jr., was that he had synthesized a new Laetrile designated roughly as beta-cyanophoric-glucuroniside which, in the presence of an enzyme, beta-glucuronidase, released quantities of nascent hydrogen cyanide. As a significant number of cancers previously have been demonstrated to develop greater amounts of beta-glucuronidase than most non-neoplastic tissues, it was maintained that the "triggering" effect of the glucuronidase on the Laetrile in cancer could produce release of free HCN in such amount as to be lethal for the cancer cell with some degree of specificity. The fact that a margin of safety exists is maintained to be due to the excess of the enzyme beta-glucuronidase in cancerous tissue.

Subsequent to our first acquaintance with the stated chemical formula of this synthetic Laetrile, Mr. Krebs has stated that related synthetic Laetriles have been developed, and he now refers to the product offered for clinical use as "Laetriles."

In addition to the foregoing sort of chemical theory offered by the proponents of this preparation they state that the fundamental biologic rationale for Laetrile therapy derives from a unitarian or trophoblastic theory of cancer, concerning which doctrine Krebs *et al.* have previously published a long treatise. So emphatic is their conviction, that Mr. Krebs has stated in correspondence that no physician should use Laetrile who does not subscribe wholeheartedly to the unitarian theory of the genesis of cancer, and that no physician can use Laetrile intelligently unless he is indoctrinated in this theory.

2. *Proponents of Laetrile treatment.* Chief claimant to the development of synthetic Laetrile is Mr. E. T. Krebs, Jr., who designates himself as a research biochemist. Associated with him is his father, Ernst T. Krebs, Sr., M.D., of San Francisco, and B. A. Krebs, D.O. Laetrile and other drugs are produced and distributed by the John Beard Memorial Foundation, organized by the Krebs and in honor of a Scottish anatomist who is said to be the originator of the unitarian theory of cancer. There are actually two John Beard Memorial Foundations, one of which is incorporated as a non-profit affair, while the other is just a "foundation."* In past years the Krebs have produced and advocated another agent for the treatment of cancer, chymotrypsin. Chymotrypsin was also said to derive its rationale in cancer from the unitarian theory of Beard, and although chymotrypsin has been quite discredited as having any effect on cancer, it is still sold and used in a limited fashion both for cancer, and for such other purposes as dissolution of blood clots in cerebral and other thromboses.

Mr. Krebs also claims to have synthesized "vitamin B_{15}," which is advocated for use in arthritis and cardiovascular disease. Various other esoteric products are distributed by the John Beard Memorial Foundation, concerning which the Cancer Commission has little or no information.

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* Note: The addresses of the two "John Beard Memorial Foundations" in San Francisco are, respectively, 642 Capp Street and 1095 Market Street. These foundations are not connected. There is also the "Krebs Research Foundation of Los Angeles," and the "Butterworth Cancer Research Grants, Inc., Los Angeles." The latter was founded by Mr. Bert Butterworth, publisher and editor of *West Coast Druggist*, with offices at 1606 N. Highland Avenue, Hollywood; the founders are Mr. A. A. Butterworth, Mrs. A. A. Butterworth, and Mr. A. W. Butterworth.

3. *Experimental evidence offered.* No satisfactory experimental evidence has been provided. Mr. Krebs states that he has demonstrated *in vitro* the triggering action of "tumor glucuronidase" on Laetrile to release nascent HCN. The Secretary of the Cancer Commission visited Dr. Ernst T. Krebs, Sr., in an attempt to obtain definitive information concerning experimental work, including toxicity tests and any available data concerning the use of Laetrile in experimental neoplasms. Dr. Krebs stated that limited trials of toxicity in laboratory animals had been performed with satisfactory results, but that the animals had been destroyed, as had the records of these trials. Dr. Krebs stated, in conversation with the Chairman of the Cancer Commission, that following demonstration of the above *in vitro* phenomenon, and satisfactory tests for toxicity, there was no point in using the agent on experimental neoplasms and that he preferred to see the agent used forthwith in human cancer.

4. *Clinical evidence offered by proponents of Laetrile.* A verbal report of the effect of Laetrile on several cases of human cancer was offered to the Secretary of the Cancer Commission by Dr. Krebs, Sr. One of these supposedly dramatic clinical situations will be representative. The story concerned a young man with a "huge cancer of the sigmoid and obstruction" (according to Dr. Krebs). The patient was "critically ill." Dr. Krebs stated that within a few minutes of administering the first dose of Laetrile the patient "could feel the action of the drug in the cancer and had a bowel movement with dramatic relief of his obstruction." Inquiry revealed that the patient had been in the Stanford University Hospital eight years previously with diffuse polyposis of the colon and rectum; he refused surgery. Two years previously he was found to have rectal carcinoma and again refused surgery. Two weeks before going to Dr. Krebs he was found by clinical and x-ray examination to have extensive rectal cancer, plus the diffuse polyposis coli, but absolutely *no* obstruction!

5. *Autopsy data offered by proponents of Laetrile.* None.

6. *Experimental evidence developed by the Cancer Commission and independent investigators.* At one medical center in Southern California an experienced experimentalist and pathologist in cancer tested Laetrile in a small group of A-mice carrying C-1300 neuroblastoma, giving 3 to 4 times the dosage employed in patients on a weight for weight basis. A similar number of control animals were used under appropriate conditions. There was no recognizable effect, gross or microscopic. The final observations were made in mice in which the neoplasms became so large under treatment with Laetrile that they were autopsied shortly before the progression of the tumor would have produced their death. It should be noted that the C-1300 neuroblastoma is a very labile neoplasm, easily controllable by a single dose of 500 roentgens of x-radiation or by one milligram per kilogram of nitrogen mustard.

A supply of Laetrile was submitted to Dr. A. P. Rinfret of the department of chemistry of Stanford University, and on January 23, 1953, Dr. C. Griffin of that department submitted the following report:

> Initially we attempted to find out how much of the preparation laboratory mice could be injected with. Two or four mg. injections had no apparent ill effects on Swiss mice. Thirty dba line 2 mice were inoculated with acute lymphatic leukemia. Two days after the tumor inoculation half of these animals were given daily injections (s.c. 2 mg. per day, the Laetrile was dissolved in saline such that 1 cc. contained 10 mg.). The remaining animals were maintained as tumor controls. All of the controls died in the period from 11 to 13 days following the tumor inoculation. Two of the Laetrile treated animals died before the 10th day, presumably from the drug itself, and the remaining animals all died between the 11th and 13th days. From this single observation involving an acute leukemia, the Laetrile exerted no effect whatsoever on the course of the disease.
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> At the present time we are injecting Laetrile into mice bearing ear tumors. Daily injections have been made for the past four weeks. At this time it would not appear that the drug has altered the course of these skin tumors. One other point may be worthy of mention. We were informed that the brown bottles contained 50 mg. of Laetrile while actually we observed that these vials contained from 25 to 35 mg. of this drug as determined by weighing on our analytical balances. A further report will be made when more data have been obtained.

John B. Field, M.D., who conducts a project in experimental screening of potential chemotherapeutic agents at U.S.C., reported as follows:

> Laetrile was studied in the cancer screening program of this department. When given at a level of 500 mg./kilogram to mice with implanted Crocker sarcoma 180, no inhibition of tumor size was obtained. This is in distinct contrast to the marked inhibition obtained in this tumor with doses of triethylene melamine at a level of .75 mg./kilo and with amethopterin at a dose of 1.5 mg./kilo.
>
> TOXICITY STUDIES
>
> The Laetrile was dissolved in saline solution and given by stomach tube to mice and found to be safe at all doses below 300 mg./kilo. However, at all oral levels of 400 mg./kilo and higher, the animals expired. Deaths were relatively in a matter of minutes with 500 mg. or higher and a matter of approximately one hour at 400 mg./kilo.

7. *Clinical evidence discovered by the Cancer Commission.* Following the initiation of the use of Laetrile at the Los Angeles County Hospital by a member of its staff, the Tumor Board and the Research Committee of the hospital decided, with the approval of the administration, that the extraordinary claims which were being made for the agent could best be either verified or disproved by a carefully controlled clinical investigation. The Tumor Board appointed a group from its Committee on

TABLE 1.—*Treatment of Cancer with Laetriles. Summary, January, 1953.*

Total patients treated		44
Alive—no evidence of cancer		1*
Alive—with cancer		17
Static	6	
Progressive	8	
Terminal	3	
Untraced with disease at last note		7
Dead		19
Autopsies	9	

* Pre-invasive carcinoma uterine cervix, biopsy diagnosis; "post-treatment" biopsy failed to show the lesion. Microscopic sections not available.

Chemotherapeutic Agents to set up and direct the investigation, the group consisting of a clinician with special experience and interest in cancer therapy, a tumor pathologist, a biochemist and a senior resident. A substantial grant was obtained from a private foundation for the support of the investigation. The proposal was to treat a series of some 30 to 50 patients over a period of six months and to follow these patients carefully over a further period of six months, recognizing that while the true effectiveness of a therapeutic agent for cancer can only be determined by long range observations over a period of years, the initial response and short term follow-up will serve to indicate whether or not an agent is worthy of further trial.

The clinician in charge of the proposed investigation at the Los Angeles County Hospital then began a frustrating experience in an attempt to obtain the promised supply of Laetrile. By this time a "foundation" had been set up in Los Angeles by the Krebs, which organization they designated as the Crabtree Research Foundation, with a Mr. C. W. Wylie as business manager. Although Laetrile was being freely issued to certain physicians for use in their offices for the treatment of cancer, Mr. Wylie and Mr. Krebs offered repeated and various excuses why Laetrile could not be furnished for the hospital investigation. Over a period of several weeks repeated assurances were given that Laetrile would be made available. Finally a communication was received in which a set of criteria was set forth, the observance of which would result in a supply of Laetrile becoming available. Most of the criteria were acceptable and conformed with good practice in pursuing a clinical investigation, but one demand was that a physician who is not a member of the attending staff of the hospital, Dr. Clifford L. Bartlett of Pasadena, be placed in charge of the investigation. The medical director of the hospital properly replied that such a demand could not be complied with, and emphasized the fact that such an investigation should be carried out by completely unbiased workers. Shortly thereafter a communication was received from Dr. Bartlett in which he undertook to notify officially the Los Angeles County Hospital that the use of Laetrile was being denied the hospital, and implied that the proposed investigation was set up with the intent of discrediting the agent. In this letter Dr. Bartlett also implied that he had done the original developmental work with Laetrile together with a biochemist, and that later the Krebs had entered the picture.

With this avenue of direct investigation thus closed, the Cancer Commission undertook to obtain information as to the clinical course of patients under treatment. On November 6, 1952, the chairman of the Cancer Commission, by invitation, reviewed a group of eight patients under treatment with Laetrile for cancer by various physicians at a sanitarium in Santa Monica. Six other patients had begun treatment with Laetrile at the Los Angeles County Hospital as described above. From these and other sources the Commission has been able to collect information on a total of 44 patients as listed in Table 2. All of the patients were treated by physicians in Southern California except two reported by Ernst T. Krebs, Sr., M.D., and one by a urologist in New Jersey.

In Table 1 is summarized the follow-up as far as it has been obtainable as of January, 1953. The information thus recorded constitutes proof that *no objective benefit* has been realized by the use of this agent in cancer. The clinical observations of several members of the Cancer Commission who have reviewed the information collected, and in some instances had an opportunity of seeing the patients thus treated, indicate that Laetrile may exert a temporary metabolic effect, probably on nitrogen metabolism. Thus some of the patients have an increase in sense of well being and appetite, and temporary gain in weight of the sort that is frequently observed with the use of any of a number of nonspecific agents. Claims have been made that Laetrile produces relief of pain in cancer, but this observation has not been verified.

Interviewing the claims which have been made for the effectiveness of Laetrile in cancer, observers for the Commission have been impressed by the fact that in almost every instance the alleged therapeutic results were ascribable to other factors. Most of the alleged improvement occurring with Laetrile was associated with one or more of the following events in the patient's disease:

(a) Subjective improvement was interpreted as being evidence of the agent's affecting the neoplasm, rather than being due to the general effect on the host, whether by metabolic or psychologic reasons. Thus, all of the physicians whose patients were reviewed spoke of increase in the sense of well being and appetite, gain in weight and decrease in pain, as though these observations constituted evidence of definitive therapeutic effect. Several patients were seen with

objective evidence of progressive neoplastic disease, two of whom came to autopsy within several weeks of their treatment with Laetrile, and yet their subjective response of increased intake of food, or the development of a euphoric mood, or some slight reduction in their use of narcotics, was accepted as objective evidence of improvement under treatment.

(b) Phases in the natural history of malignant neoplasm not infrequently observed in patients who are receiving no treatment whatever were interpreted as being due to the therapy employed. Thus a woman on exploratory laparotomy was found to have a bulky ovarian carcinoma with extensive peritoneal implants. Shortly after this surgical procedure, at which nothing more than biopsy for confirmation of the diagnoses was done, she began treatment with Laetrile. Her subsequent improvement generally, the failure of the ascites to recur, and the fact that she became ambulatory and fairly active, were interpreted as therapeutic effect. It is common knowledge among clinicians of experience that occasional patients with widespread peritoneal carcinomatosis will exhibit remarkable spontaneous arrest, or even regression of their disease following simple exploratory procedures. The same observation has been made in patients explored with the finding of extensive tuberculous abdominal lesions.

(c) Most often the patients reported as showing regression of cancer with Laetrile were either receiving concurrent treatment by other methods, or had in their recent past been treated by some more conventional techniques and were exhibiting a degree of control of their disease entirely attributable to the previous treatment. An example of a situation of this sort was illustrated by a man who was presented to a member of the Commission as being a dramatic example of control of bronchogenic carcinoma, with metastases, by Laetrile. Serial roentgenograms were shown of a patient who had a left pulmonary apical lesion, with enlarged left supraclavicular nodes, biopsy of one of which had shown metastatic carcinoma compatible with a primary bronchogenic lesion. Over a period of some three months, during which time he had had treatment first with chymotrypsin, and then with Laetrile, the roentgenograms showed almost complete regression of the pulmonary lesion. When the patient was examined there was noted a residual erythema and early tanning of the skin over a rectangular area which lay directly over the pulmonary lesion, and extended upward over the supraclavicular area. Inquiry revealed that the patient had, some six weeks previously, completed a full course of high voltage x-ray therapy, but the physician who had employed the Laetrile was unaware that the radiation had been directed toward the pulmonary lesion, thinking that anatomically the field had covered only the lymphnodal metastases.

(d) A few of the patients treated did not have proof of the presence of cancer in the form of histological diagnoses, the evidence being more or less inferential, as radiographic observation of lesions in the lung, or a surgeon's diagnosis of a lesion as cancerous on observations of gross pathology at operation, without confirmation with biopsy.

(e) Very few of the clinical records to which the Cancer Commission has had access contain any sort of satisfactory evidence as to objective, accurate evaluation of the progress of the primary neoplasm or its metastases while under treatment. In the instance of accessible lesions there was no record of any actual measurement of the presenting neoplasm.

In short, the clinical observations offered on the course of patients treated with Laetrile are all too frequently distorted by a lack of appreciation of the natural history of cancer on the part of the physician using the agent. This is not to say that the physicians in such a situation are not without ability in their own field. An internist, however, may

TABLE 2.—*Clinical Summary—Laetrile.*

No. and Diagnosis	Present Status	Autopsy
1. Multiple myeloma	Alive with disease	
2. Squamous ca. lt. antrum	Alive with disease	
3. Not recorded	Active disease	
4. Adenoca. of ovary with metastases	Terminal	
5. Ca. of the vulva	Progressive disease	
6. Pulmonary and skeletal metastases	Progressive disease	
7. Adenoca. of ascending colon, Gr. III with metastases	Not known	
8. Melanoma—primary in scalp	Progressive disease	
9. Adenoca. of lt. breast, Gr. III with metastatic adenoca. of axillary nodes Cystic adenoca. of the ovary	Bedridden	
10. Ca. of right ovary	Alive with disease	
11. Metastatic tumor causing obstruction rt. kidney	Progressive disease	
12. Multiple myeloma	Active disease	
13. Ca. rt. breast, Gr. III	Progressive disease	
14. Papillary serous cyst-adenoca. Gr. II, lt. ovary with extensive metastases	Not known	
15. Testicular tumor	Died	Yes
16. Neoplasm involving entire stomach with extensive metastases	Unimproved	
17. Papillary epidermoid ca. low grade, gingiva	Active disease	
18. Squamous epithelioma, primary lt. lung upper lobe, with metastases	Alive with disease	
19. Postop. adenoca. rt. breast, Gr. IV	Alive with disease	
20. Preinvasive epidermoid ca. of uterus	Well	
21. Infiltrating epidermoid ca., Gr. II-III, uterine cervix, Gr. IV	Alive with disease	
22. Hypernephroma with metastases	Died	No
23. Metastatic ca.—primary in ovary	Died	No
24. Ca. of rectum	No change	
25. Ca. of colon	No change	
26. Ca. of lung	Bedridden	
27. Ca. of bladder	Progressive disease	
28. Metastatic ca. of liver	Died	Yes
29. Reticulum cell lymphosarcoma	Died	Yes
30. Gastric carcinoma	Died	Yes
31. Ca. of breast	Died	Yes
32. Ca. of colon	Died	Yes
33. Ca. of cervix uteri	Died	Yes
34. Ca. of pancreas	Died	Yes
35. Teratoma of testis	Died	Yes
36. Ca. of breast	Died	No
37. Ca. of breast	Died	No
38. Leukemia	Died	No
39. Invasive ca. of uterus	Died	No
40. Adenoca. rt. alveolar ridge, massive neck metastases	Died	No
41. Ca. of breast, metastases	Died	No
42. Sq. cell ca. rt. lung	Died	No
43. Anaplastic adenoca., primary site unknown	Died	No
44. Generalized carcinomatosis of abdomen	Not known	

have little knowledge of the natural history, and response to treatment, of some forms of gynecologic or urologic cancer. Generally there has also been a failure to differentiate between subjective and objective response, and specific and non-specific effects of treatment.

One further example of an unwarranted claim for this agent is the instance of a patient who was treated for a preinvasive carcinoma of the uterine cervix. The reported observation of carcinoma *in situ* being present in the pre-treatment biopsies, is of no possible significance. It is known that carcinoma *in situ*, particularly in the uterine cervix, is capable of undergoing spontaneous regression. Further, it has been established repeatedly that occasional women showing this lesion on biopsy will come to total hysterectomy, and the pathologist will be unable to find further malignant change in the surgical specimen even with a large number of serial sections of the cervix. Finally the differentiation between atypical epithelial hyperplasia and actual preinvasive carcinoma may be a debatable issue in some instances, and the Commission has not had an opportunity to have the sections in this particular case reviewed.

8. *Autopsy data reviewed by the Cancer Commission.* Adequate information in the instance of six autopsies of patients treated for cancer with Laetrile and microscopic sections of the neoplasm were obtainable for review in nine cases. The material from six of these autopsies was collected at one time, wet tissue was obtained from the pathologist who did the autopsies, and sets of microscopic sections were prepared for review. The cases so collected at this time appear in Table 2 as Numbers 28 to 33 inclusive. This material was sent to three consultants who have had particular experience and interest in tumor pathology, Louisa E. Keasbey, M.D., John W. Budd, M.D., and J. L. Zundell, M.D. Subsequently microscopic sections were obtained from autopsies done in three additional cases appearing in Table 2 as Numbers 13, 34 and 35. Two of these latter cases were reviewed for the Commission by Weldon K. Bullock, M.D. and the other by A. R. Camero, M.D. In addition, the sections from the original group of six autopsied patients were submitted to Fred W. Stewart, pathologist to the Memorial Center for Cancer and Allied Diseases in New York.

The unanimous opinion of these consultants was that in no instance could any recognizable effect of a chemotherapeutic agent be observed in the histology of these various neoplasms. Some of the proponents of Laetrile had reported microscopic observations in the form of necrosis and hemorrhage in some instances, and sclerosis in others, which they interpreted as being the result of specific action of Laetrile on the neoplasm. Although both of these changes were observed by the consultants in a number of the cases studied, such changes in each instance were entirely consistent with vascular changes, necrosis and stromal sclerosis regularly seen in such neoplasms, both treated and untreated. Even in those cases showing considerable necrosis, particularly in hepatic metastases, there were invariably large areas of well preserved and viable tumor tissue. No evidence of cytotoxic changes was observed by any of the consultants. Dr. Fred W. Stewart reported, "I don't see anything in any of these cases that is the least bit suggestive of treatment effect, nor do I see anything that is foreign in appearance to appearances at autopsy of any cases of the corresponding type."

9. *Consultants' reports.* As outlined under Item 1 of this report the claim by Krebs and his associates for the possible value of the Laetriles in the treatment of cancer was based on the concept that an excess of the enzyme beta-glucuronidase in cancer tissue acted as a focal trigger mechanism in producing the release of free HCN from the Laetriles, and thus there might be a specificity of parenterally administered Laetrile on foci of cancer in the host. In a copy of a manuscript written by Ernst T. Krebs, Jr. *et al*, presumably for publication, the following statements are made:

(a) That the natural nitriles as obtained from apricot pits are beta-cyanophoric glucosides, that these natural glucosides were used by Krebs Sr. in the early '20s of this century with "substantial clinical results" due to the presence of a "beta-cyanogenetic glucoside (amygdalin)."

(b) The claim of Krebs Jr. that he has synthesized a laetrile which he designates as a beta-cyanophoric glucuronoside. The manuscript states that "the natural laetriles have been abandoned for the more specific synthetic laetrile tailored as specific glucuronosidic substrates for the tumor beta-glucuronidase." The manuscript also states that the synthetic laetrile has the advantage of being a smaller molecule with less possibility of proving antigenically or otherwise reactive.

It seemed essential, therefore, to obtain expert opinion as to the theoretical basis for this supposed action, and to obtain an analysis of the product distributed by Krebs as Laetrile.

The opinion of Dr. Jesse P. Greenstein, chief of the laboratory of biochemistry at the National Cancer Institute was obtained in respect to the distribution of beta-glucuronidase in neoplastic and non-neoplastic tissues, and as to the implication that there was a "tumor" beta-glucuronidase enzyme. The fact is, reported Doctor Greenstein, that beta-glucuronidase is found in all tissues of the animal body and in particularly high concentration in spleen, liver and endocrine organs, as well as in plasma and in tumors arising from estrogen influenced tissues. Per gram of tissue the spleen and liver have a higher concentration of beta-glucuronidase than do

most tumors, and these normal organs together weigh far more than most tumors. In other words, there is much more "normal" beta-glucuronidase than "tumor" beta-glucuronidase in any animal body.*

For analysis samples of Laetrile were submitted to the chemical laboratory of the American Medical Association, in the form of a box of four ampules containing a white crystalline powder and labelled as Laetrile. Comparison of this material was carried out by various chemical methods with a sample of amygdalin purchased on the open market. Comparison was also made between the two materials by ultra-violet absorption spectra. The conclusion of this analysis and comparative study was that the Laetrile tested was essentially amygdalin with a small amount of other material present.

An analysis on samples submitted as Laetrile is being done by John W. Mehl, M.D., professor of biochemistry at the University of Southern California. A preliminary report was submitted by Dr. Mehl on February 27, 1953, as follows:

> We have tested the material for the presence of carboxyl groups, which must be present in a *glucuronoside*. The amount is so small that this could constitute only about 1 per cent of the total material. I would conclude that the material, if a glycoside, is probably a glucoside as suggested by the examinations of others.
>
> I also made an attempt to hydrolyze the material with beta-glucuronidase, and to collect any evolved HCN by inserting a wick of filter paper which had been moistened with dilate NaOH in the stopper. After 48 hours at 25° C, no HCN was detectable by the alkaline picrate test, carried out as a spot test.
>
> These results are inconclusive, and will be extended, but they do not support the claims made for Laetrile.

10. *General comments.* The efforts of the Cancer Commission to develop information concerning the Krebs and their various foundations, the distribution of Laetrile and its use by a number of physicians have been attended by a constant series of conflicting statements, claims being made and then denied, supplies of Laetrile repeatedly being promised for clinical or experimental use and eventually refused, and above all repeated implications that the intent of the Cancer Commission was only to discredit out of hand this proposed treatment for cancer. In one of a series of long communications Mr. Krebs remarked "it is extremely unlikely that any paper describing positive findings for Laetrile could achieve early publication in J.A.M.A., though it is virtually a certainty that a paper describing no results would find ready acceptance." At times Mr. Krebs has said that he makes no claim for any established value of Laetriles in cancer, at other times he describes the remarkable results obtained—offering as supportive evidence the sort of necrosis referred to in the description of the autopsy material in this report. Mr. Krebs also wrote to the Cancer Commission maintaining that "during the past 50 years a number of terminal cancer patients have recovered as the result of the use of either trypsin or chymotrypsin." Dr. Krebs, Sr., however, when pressed by the secretary of the Cancer Commission, stated that he could not produce any examples of cancer control by chymotrypsin.

In further communication with the Commission, Mr. Krebs wrote to outline his ideas of how a clinical project should be set up to evaluate the efficiency of a treatment for cancer, and wrote that they had criteria other than that of tumefaction by which they evaluated Laetrile therapy.

Their preferred criteria as listed were: (1) Decrease in pain, (2) Increase in appetite, (3) Increase in weight, (4) Increase in muscular strength and general sense of well-being, (5) Decrease in sedimentation rate, (6) Some decrease in tumefaction, (7) Increase in life expectancy, (8) Histological changes, (9) Necrotic involution and (10) Intense local reaction in the primary and secondary lesions.

When information reached Mr. Krebs that preliminary results of the analysis of Laetrile being done at the A.M.A. chemical laboratory indicated that only amygdalin was present, he began a new round of correspondence to remind his group and the Commission that he had always said that the natural laetrile, or amygdalin, was part of the "remedy," and gave more emphasis to his previous statements that he did not maintain that laetrile was necessarily an effective treatment for cancer.

The financial background of the production and distribution of Laetrile has naturally been of some interest to investigators. Krebs maintains that the development of the agent has been extremely costly, while some of the physicians who have been using the material in private practice have maintained that their charges have been modest indeed. The Commission has a witnessed statement from a patient who visited one of these physicians to discuss treatment of his Hodgkin's disease with Laetrile. The patient's statement certifies that he was advised to try one week of treatment, during which three injections of Laetrile would be given at a cost of $50.00 each. In addition, three injections of vitamins would also be given, presumably the so-called Vitamin B_{15}, also manufactured by Krebs, and the cost of this would be $10 each time. Thus the trial period of one week's treatment would cost this patient, a young man with modest income, a total of $180. One of the physicians using Laetrile has informed the Commission that it is supplied to him by Krebs at the cost of $10 per ampule, and the Vitamin B_{15} at a cost of $3 per ampule.

* Dr. Greenstein writes in a letter dated November 10, 1952: "Such a statement as. . .'the malignant cell . . . is virtually an island surrounded by a sea of beta-glucuronidase' is sheer nonsense."

In one instance of a patient with an operable gingival carcinoma under treatment with Laetrile, three requests were made for serial biopsies of the lesion while under treatment, as a pre-treatment biopsy was already in our possession. Repeated assurances were given us that biopsies would be obtained. We offered to assist in any way desired, but no material was received.

11. *Conclusions of the Commission.* Laetriles have been advocated for the treatment of cancer on the basis of the following claims:

(a) That one or more synthetic laetriles have been synthesized.

(b) That in the presence of the enzyme beta-glucuronidase, supposedly present in excess in cancer tissue, a chemical reaction occurs resulting in the liberation of nascent HCN.

(c) That the HCN thus produced has, at least to some extent, a selective cytotoxic effect on the cancer cell.

The evidence accumulated by the Cancer Commission and its consultants indicates the following defects in these claims, in the following order:

(a) Chemical analyses done independently for the Commission have identified in the product distributed as Laetrile only the presence of a natural laetrile termed amygdalin.

(b) The enzyme beta-glucuronidase, while present in some excess in some types of cancer, is also present in similar concentrations in normal tissue such as liver and spleen. In fact, the total amount of beta-glucuronidase present in normal tissues in almost any cancer patient considerably exceeds that which is present in neoplastic tissue.

(c) No satisfactory evidence has been produced to indicate any significant cytotoxic effect of Laetrile on the cancer cell.

The Commission has collected information concerning 44 patients treated with Laetrile, all of whom either have active disease or are dead of their disease, with one exception. Of those alive with disease, no patient has been found with objective evidence of control of cancer under treatment with Laetriles alone.

Nine patients dying from cancer after treatment with Laetrile have been autopsied, and histological studies done for the Commission by five different pathologists have shown no evidence of any chemotherapeutic effect.

In two independent studies by experienced research workers, Laetrile has been completely ineffective when used in large doses on cancer in laboratory animals, in lesions which are readily influenced by useful chemotherapy.

The American Cancer Society: What It Is; What It Does

THE AMERICAN CANCER SOCIETY, which will conduct its annual educational and fund raising crusade during the month of April, is the only voluntary agency operating throughout California with a program of cancer research, education and service. It receives no funds from the government fisc but is supported entirely by donations from the public.

The Cancer Society has official approval of the California Medical Association and of the county medical societies in the areas in which it is active. It has branches in 34 counties of California and informal county committee organizations in twelve others.

Members of the Cancer Commission of the California Medical Association automatically are elected to concurrent membership on the board of directors of the California division of the society. Members of County Medical Society cancer committees also serve automatically on the boards of directors of the various Cancer Society branches.

During the past year the society joined with the Cancer Commission in arranging 31 Cancer Conferences for the medical societies of counties remote from medical teaching centers. The society also gave financial assistance to 60 consultative tumor boards which were approved by the Cancer Commission.

In addition to providing speakers and films for professional meetings, the society sends *CA: A Bulletin of Cancer Progress* to 4,300 California physicians in general practice who have requested it. Each year it distributes at least one monograph, written by a recognized authority, without charge to all physicians in the state. Two were issued last year, covering the subjects of cancer of the esophagus and stomach and malignant lymphomas and leukemias.

The society's principal effort, however, is in the fields of cancer research and general public education. Its program of public education reaches an annual peak in April, which is proclaimed nationally as Cancer Control Month. During this period the society endeavors to impress upon millions of Americans the seven danger signals of cancer and the need for prompt recognition and treatment of the disease.

The funds it collects are used also to maintain a research program which is the backbone of the society's activities. Some of the most important phases of this research program are being carried out in the institutions of this state.

The society invites the cooperation of all physicians in its activities, not only during the period of the fund-raising drive but throughout the year. It particularly urges them to participate as speakers in its public education campaign.

Council Meeting Minutes

Tentative Draft: Minutes of the 397th and 398th Meetings of the Council of the California Medical Association.

397th Meeting

The meeting was called to order in the Golden Empire Room of the Hotel Mark Hopkins, San Francisco, at 12:15 p.m., Saturday, December 6, 1952, by Chairman Shipman.

Roll Call:

President were President Alesen, President-Elect Green, Speaker Charnock, Vice-Speaker Bailey, Secretary Daniels, Editor Wilbur and Councilors Shipman, West, Wheeler, Loos, Sampson, Morrison, Dau, Ray, Montgomery, Lum, Bostick, Pollock, Frees, Carey, Kirchner and Heron.

Absent for cause, Councilor Varden.

A quorum present and acting.

Present by invitation during all or a part of the meeting were Messrs. Hunton, Thomas, Clancy, Gillette and Pettis of C.M.A. staff, Legal Counsel Hassard, Mr. Ben Read of the Public Health League of California, Legislative Chairman Doctor Dwight H. Murray, county society executive secretaries Thompson of San Joaquin and Donovan of Santa Clara and Doctors E. Vincent Askey, Francis J. Cox, Sam McClendon, Samuel R. Sherman, Abraham Sirbu, Dan Kilroy, James C. Doyle, Henry Gibbons III, H. Gordon MacLean and Joseph S. McGuinness.

1. *Minutes for Approval:*

On motion duly made and seconded, minutes of the 396th meeting of the Council, held November 15-16, 1952, were approved.

2. *Membership:*

(a) On motion duly made and seconded, two delinquent members whose dues had been received, were voted reinstatement.

(b) On motion duly made and seconded, Doctor Cloyd N. McAllister of Madera County was elected to Associate Membership.

(c) On motion duly made and seconded, Doctor Kenneth J. Dunlavy of Sonoma County was elected to Retired Membership.

(d) On motion duly made and seconded in each instance, seven applicants were voted a reduction of dues because of protracted illness or postgraduate study.

(e) Report was made on the expulsion of one member from the Los Angeles County Medical Association following hearings on charges of unprofessional conduct.

3. *Annual Session:*

On motion duly made and seconded, approval was voted the President to invite Dean Manion of the School of Law, Notre Dame University, as the President's guest speaker at the 1953 Annual Session, it being understood that arrangements would be made to provide Dean Manion with a suitable separate meeting to which the public might be invited.

On motion duly made and seconded, it was voted to invite Doctor Leonard Scheele, Surgeon General of the U. S. Public Health Service, to address the 1953 Annual Session on the occasion of his visit to Los Angeles on official business.

4. *Professional Disability Insurance:*

Councilor Kirchner reported on the study made by his committee of a group disability insurance program which had been offered the Association. After discussion, it was regularly moved, seconded and voted to approve the committee's report and to refer the subject to the Executive Committee for further study and report.

5. *Committee on Industrial Accident Commission:*

Doctor Francis J. Cox, chairman of the Committee on Industrial Accident Commission, gave a progress report on the committee's activities, including the filing of a petition to the Industrial Accident Commission for approval of a proposed new fee schedule. On motion duly made and seconded, it was voted to authorize the committee, working with the Committee on Public Policy and Legislation, to instigate legislation on the subject of authority of a state agency to inaugurate and enforce a schedule of medical and surgical fees, in the event a satisfactory reply on the current petition is not received by next January 1.

6. *Referee for Disciplinary Case:*

On motion duly made and seconded, it was voted to appoint a referee to conduct a hearing by the Riverside County Medical Association on charges of unprofessional conduct brought against one of its members.

Recess

At this point, 1:30 p.m., Saturday, December 6, 1952, the meeting was recessed until 12:00 noon, Sunday, December 7, 1952.

7. *Special Committee on Psychiatry:*

Dr. Alesen reported on a study made by a special committee on psychiatry on the report of research work performed in a state hospital. On motion duly made and seconded, it was voted to request this committee to make such further studies on this subject as might be indicated.

On motion duly made and seconded, it was voted

to appoint a committee on nutritional studies in state hospitals, subject to the consent and advice of Dr. Dwight L. Wilbur, who has conducted a nutritional study on this subject.

8. *Bureau of Mental Health:*

Councilor Carey reported on the opening of an office by the Bureau of Mental Health, Department of Mental Hygiene, in which a state psychiatrist offers psychiatric service to all patients, including some in whose cases there is a question as to the social servicing employed. On motion duly made and seconded, it was voted to advise the county societies on the action previously taken by the Council in regard to private practice by physicians employed in state institutions.

9. *California Medicine:*

Editor Wilbur discussed a proposal that CALIFORNIA MEDICINE be augmented by the addition of (1) increased reporting on Association activities and considerations and (2) editorials and reports on medical-economic subjects, social problems, legal matters, medical education and other subjects. He suggested that the President, President-elect, Council Chairman and Secretary sit with the Editor as an advisory board on the selection and form of such material. On motion duly made and seconded, it was voted to authorize the Editor to proceed along the lines outlined.

10. *Professional Liability Insurance:*

A letter from a county society, outlining its objections to the exclusion of specified risks from its professional liability policies, was read and discussed. It was regularly moved, seconded and voted to refer this matter to the Committee on Medical Defense.

11. *Public Policy and Legislation:*

Dr. Dwight H. Murray, legislative chairman, reported on a meeting held by his committee with the special Committee on Psychology and invited psychologists. Dr. Bullock's written report was distributed to each Councilor and considered. On motion duly made and seconded, it was voted to refer the matter of suggested legislation in the field of psychology to the Committee on Public Policy and Legislation for further consideration.

12. *Department of Public Health:*

A communication from Dr. Garnett Cheney on the subject of rabies control and milk pasteurization and certification was read. Dr. Cheney urged that the Association undertake joint action with the State Department of Public Health along the lines of more adequate public control of these matters and on motion duly made and seconded, it was voted to approve such joint action.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 2:00 p.m., Sunday, December 7, 1952.

SIDNEY J. SHIPMAN, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

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398th Meeting

The meeting was called to order by Chairman Shipman in Room 220 of the St. Francis Hotel, San Francisco, at 9:30 a.m., Sunday, February 22, 1953.

Roll Call:

Present were President Alesen, President-elect Green, Speaker Charnock, Vice-Speaker Bailey, Councilors West, Wheeler, Loos, Sampson, Morrison, Dau, Ray, Lum, Bostick, Pollock, Frees, Carey, Shipman, Kirchner and Heron, Secretary Daniels and Editor Wilbur.

Absent for cause: Councilors Montgomery and Varden.

A quorum present and acting.

Present by invitation during all or a part of the meeting were Messrs. Hunton, Thomas, Clancy, Pettis and Gillette of C.M.A. staff; Legal Counsel Howard Hassard; Drs. Dwight H. Murray, Francis T. Hodges and Francis J. Cox; county society executive secretaries Waterson of Alameda-Contra Costa, Geisert of Kern, Nute of San Diego, Wood of San Mateo and Donovan of Santa Clara; Dr. Malcolm Merrill of the State Department of Public Health; Mr. Ben H. Read of the Public Health League of California; Mr. K. L. Hamman of California Physicians' Service; Dr. John S. O'Toole, secretary of the Riverside County Medical Association; Mr. Clem Whitaker, Jr., of public relations counsel, and Drs. John W. Cline and Edwin L. Bruck.

1. *Minutes for Approval:*

(a) On motion duly made and seconded, minutes of the 397th Council meeting, held December 6-7, 1952, were approved.

(b) On motion duly made and seconded, minutes of the 235th Executive Committee meeting, held December 20, 1952, were approved.

(c) On motion duly made and seconded, minutes of the 236th Executive Committee meeting, held February 1, 1953 were approved.

2. *Membership:*

(a) A report of membership as of February 20, 1953, was received.

(b) On motion duly made and seconded, five members delinquent for 1952 and one delinquent for 1951 and 1952 were voted reinstatement.

(c) On motion duly made and seconded in each

instance, four applicants were elected to Associate Membership. These were: Charles R. Gardipee, Alameda-Contra Costa; Arthur R. Jewel, Napa County; J. T. Shelton, and Robert S. Westphal, Sonoma County.

(d) On motion duly made and seconded in each instance, 17 applicants were elected to Retired Membership. These were: Harry Abrons, Wm. C. Pruett, Roscoe Van Nuys, Alameda-Contra Costa; A. H. Konigmacher, R. J. van Wagenen, Fresno County; R. Elsie Arburthnot, George W. Blatherwick, A. Newton Bobbitt, C. F. Charlton, Ralph C. Christie, Wm. L. Goeckerman, John P. Naughton, Wendy Stewart, C. G. Sutherlin, Cleon W. Symonds, Los Angeles County; George E. Chapman, San Francisco County; and George A. Broughton, Ventura County.

(e) On motion duly made and seconded in each instance, 26 applicants were voted leaves of absence.

(f) On motion duly made and seconded in each instance, three applicants were voted reductions of dues.

(g) On motion duly made and seconded, it was voted to authorize the central office to handle administratively the applications for leaves of absence or reduction of dues for members over the age of 70 years or those in their first three years of practice, subject to Council approval.

(h) On motion duly made and seconded, it was voted to appoint a referee to conduct a disciplinary hearing in Los Angeles County.

(i) On motion duly made and seconded, it was voted to hear an appeal from a Los Angeles County disciplinary case at 10 a.m., Saturday, May 23, 1953, in Los Angeles, with written briefs to be filed in advance by both parties and with Dr. L. A. Alesen appointed a conciliation committee of one to attempt a conciliation in this matter.

3. *Financial:*

A report of bank balances as of February 20, 1953, was received and ordered filed.

4. *Alternate Delegate to American Medical Association:*

In accordance with the terms of Chapter VIII, Section 9, of the By-Laws, and on motion duly made and seconded, Dr. Orris R. Myers of Eureka was elected an Alternate Delegate to the American Medical Association, as alternate to Delegate John W. Green.

5. *Nominations for C.P.S. Board of Trustees:*

On motion duly made and seconded, the following nominations for the Board of Trustees of California Physicians' Service were approved: Merlin L. Newkirk, M.D., to succeed Donald Cass, M.D.; Leon O. Desimone, M.D., to succeed Kendrick A. Smith, M.D.; Francis T. Hodges, M.D., to succeed himself; Mr. Robert A. Hornby to succeed himself; Edwin L. Bruck, M.D., for the vacancy created by the resignation of Harold M. F. Behnemann, M.D.

6. *Advisory Planning Committee:*

Mr. Hunton reported on the meeting of the Advisory Planning Committee held February 20, 1953, and recommended that Eldon E. Geisert, newly appointed executive secretary of the Kern County Medical Society, be appointed a member of the committee. On motion duly made and seconded, this appointment was voted. Mr. Hunton also presented the following resolution, which, on motion duly made and seconded, was unanimously adopted:

WHEREAS, In the March, 1953, issue of the *Reader's Digest*, in an article entitled, "The Modern Man of Medicine," much favorable publicity is given to the Alameda-Contra Costa Medical Association's progressive public relations program; and

WHEREAS, The entire membership of the California Medical Association basks in the honor bestowed upon this Association; and

WHEREAS, Much credit for this extremely favorable article, as well as the philosophy and program which it describes, should go to Rollen A. Waterson, executive secretary of the Alameda-Contra Costa Medical Association; now, therefore, be it

Resolved: That on this 22nd day of February, 1953, the Council of the California Medical Association extend to the Alameda-Contra Costa Medical Association, and its executive secretary, Rollen Waterson, its congratulations and best wishes.

7. *California Physicians' Service:*

Dr. Francis T. Hodges reported on the beneficiary and physician membership of California Physicians' Service and gave a progress report on the activation by the C.P.S. Board of Trustees of recommendations adopted by the 1952 House of Delegates.

8. *Blue Shield-Blue Cross Meetings:*

On motion duly made and seconded, it was voted that it be the sense of the Council that the chair appoint a committee to explore all aspects of Blue Shield and Blue Cross operations in southern California, with a view toward possible joint operations by the two organizations.

It was further moved, seconded and voted that President Alesen be authorized to arrange a joint meeting of representatives of the two organizations.

(Chairman Shipman appointed Dr. Alesen as chairman of the committee, with Dr. Ben Frees and Mr. Ritz Heerman as the other members.)

9. *Public Policy and Legislation:*

Dr. Dwight H. Murray reported on meetings held

in Washington between officials of the American Medical Association and Mrs. Oveta Culp Hobby, Federal Security Administrator, and President Eisenhower.

Mr. Read and Mr. Hassard reported on several legislative items under consideration by the Committee on Public Policy and Legislation. The committee pointed out that (1) legislation has been introduced to permit telephoned prescriptions for codeine and codeine mixtures, and (2) that such telephoned prescriptions be taken subject to later issuance of a written prescription.

On motion duly made and seconded, it was voted to recommend that telephoned prescriptions for dangerous drugs be recognized, subject to furnishing of a written prescription within 72 hours.

On motion duly made and seconded, it was voted to oppose current legislative proposals calling for the State of California to enter the disability insurance field in competition with private industry.

10. *Committee on Industrial Accident Commission:*

Dr. Francis J. Cox reported on the status of his committee's negotiations for an adequate fee schedule for industrial accident cases. Legislation has been introduced to clarify the legal position in establishment of such a schedule.

11. *State Department of Public Health:*

Dr. Malcolm Merrill, Assistant Director of Public Health, reported that about 1,000,000 doses of gamma globulin would probably be available for the nation during the polio season and that all available serum has been withdrawn from the commercial market and placed in a national pool. The State Department of Public Health is working with the Association, the California Conference of Local Health Officers and several technical consultants on the problems of distribution of the small amount of serum which will become available.

On motion duly made and seconded, it was voted to prepare a news release, in conjunction with the State Department of Public Health, on the impending shortage of gamma globulin.

On motion duly made and seconded, it was unanimously voted to express to Dr. Wilton L. Halverson, State Director of Public Health, the approval of the Council of his services in his official capacity and the sincere hope that he will remain in California to continue his good work.

Councilor Carey and Dr. Henry Eagle, secretary of the Shasta County Medical Society, discussed the psychiatric services offered in some rural areas by the State Department of Mental Hygiene. On motion duly made and seconded, it was voted to refer this matter to the Committee on Public Health and Public Agencies.

12. *Public Relations:*

Dr. Pollock and Messrs. Hassard and Gillette reviewed some staff questions which have arisen in hospital districts in various places. The public relations department has been asked to assist in some phases of this problem.

Discussion was held on plans now being made in the San Francisco bay area for establishment of an educational television station. It was pointed out that public service time will likely be made available by some of the existing television outlets in this and other areas of the state.

13. *Group Disability Insurance:*

Councilor Kirchner reported that the group disability insurance program offered for members of the Association was to be reviewed by an independent insurance analyst. He also discussed the health insurance needs of medical students and their dependents.

Councilor Wheeler reported that the Riverside County Medical Society and C.P.S. were cooperating in setting up a prepayment medical care program for the University of California at Riverside.

On motion duly made and seconded, it was voted to request the C.P.S. Board of Trustees to investigate the possibility of providing medical services for students throughout the state.

14. *Committee on Scientific Work:*

Secretary Daniels presented a list of guest speakers and non-members who will contribute papers at the 1953 Annual Session. On motion duly made and seconded, this list was approved.

15. *State Bar of California:*

A request was presented from the State Bar of California for appointment of a committee to work with a similar committee from the State Bar on a new legal definition of insanity. On motion duly made and seconded, the chairman was authorized to appoint such a committee.

16. *1952 House of Delegates:*

Discussion was held on a resolution presented to the 1952 House of Delegates, calling for the establishment of the Department of Public Relations as a separate organization from the Association office. This resolution was defeated in the House of Delegates but referred to the Council for consideration. On motion duly made and seconded, it was voted to continue the Department of Public Relations in its present state.

17. *Medical Student Training:*

Dr. Charnock reported on work being done by Jerry Pettis of public relations staff in indoctrinating medical students. On motion duly made and sec-

onded, it was voted to encourage this activity and to furnish reasonable financing for it.

18. *School of Health Programs:*

Discussion was held on the proposal that the Association foster the establishment of organized school health programs in the various areas of the state. On motion duly made and seconded, it was voted to empower Dr. D. H. Murray to discuss this proposal with the school health authorities in the American Medical Association.

Adjournment:

The Chairman called attention to the fact that the Council's business now requires either one long day or two days to complete. He suggested that in future meetings Councilors who must travel plan to return by late planes or trains or be prepared to spend two days in session.

There being no further business to come before it, the meeting was adjourned at 6:10 p.m.

SIDNEY J. SHIPMAN, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

In Memoriam

ADAMS, BON O. Died in Riverside, February 23, 1953, aged 80, of arteriosclerotic heart disease. Graduate of the Medical College of Indiana, Indianapolis, 1901. Licensed in California in 1916. Doctor Adams was a member of the Riverside County Medical Association, the California Medical Association, and the American Medical Association.

✤

BAILEY, CORNELIUS O. Died in Los Angeles, February 1, 1953, aged 65, of cardiac failure. Graduate of the University of Texas School of Medicine, Galveston, 1915. Licensed in California in 1931. Doctor Bailey was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

BOLIN, ZERA E. Died in San Francisco, February 11, 1953, aged 64. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1914. Licensed in California in 1923. Doctor Bolin was a member of the San Francisco Medical Society, the California Medical Association, and the American Medical Association.

✤

CLOUGH, DAVID M. Died January 22, 1953, aged 44, when an airplane he was piloting crashed into a mountain side near Round Mountain, California. Graduate of the University of Minnesota Medical School, Minneapolis, 1942. Licensed in California in 1942. Doctor Clough was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

CLOUGH, FRANCIS E. Died in Laguna Beach, February 9, 1953, aged 74, of coronary artery disease. Graduate of Rush Medical College, Chicago, Illinois, 1902. Licensed in California in 1928. Doctor Clough was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Medical Association.

✤

ELLWOOD, WALTER M. Died in Hollywood, February 7, 1953, aged 46, of coronary artery disease. Graduate of Marquette University School of Medicine, Milwaukee, Wisconsin, 1931. Licensed in California in 1944. Doctor Ellwood was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

GIRARD, FRANK R. Died in Tucson, Arizona, February 28, 1953, aged 72, from injuries received in a fall from a horse at a guest ranch near the Arizona city. Graduate of the University of California Medical School, Berkeley-San Francisco, 1903. Licensed in California in 1914. Doctor Girard was a retired member of San Francisco Medical Society, the California Medical Association, and an associate member of the American Medical Association.

✤

HONAKER, GEORGE T. Died in San Leandro, February 22, 1953, aged 75. Graduate of Barnes Medical College of St. Louis, Missouri, 1900. Licensed in California in 1920. Doctor Honaker was a retired member of the Alameda-Contra Costa Medical Association, and the California Medical Association, and an associate member of the American Medical Association.

✤

ROSSON, CHARLES T., JR. Died in Hanford, February 3, 1953, aged 47. Graduate of the University of California Medical School, Berkeley-San Francisco, 1931. Licensed in California in 1931. Doctor Rosson was a member of the Kings County Medical Society, the California Medical Association, and the American Medical Association.

✤

TAYLOR, ROY N. Died December 20, 1952, aged 56. Graduate of the University of Tennessee College of Medicine, Memphis, 1924. Licensed in California in 1925. Doctor Taylor was a member of the Riverside County Medical Association, and an associate member of the California Medical Association, and the American Medical Association.

✤

WEBER, WILLIAM L. Died in Durham, North Carolina, January 30, 1953, aged 67, of cardiovascular disease. Graduate of the University of Southern California School of Medicine, Los Angeles, 1908. Licensed in California in 1908. Doctor Weber was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an associate member of the American Medical Association.

NEWS & NOTES

NATIONAL · STATE · COUNTY

LOS ANGELES

Dr. Norman Q. Brill has been selected to head a coordinated mental hygiene program by the University of California at Los Angeles School of Medicine and the State Department of Mental Hygiene, it has been announced by Chancellor Raymond B. Allen of U.C.L.A.

Dr. Brill will serve both as chairman of the department of psychiatry at the new Medical Center and as director of a State Department Mental Hygiene Unit to be built near the Los Angeles campus.

* * * *

The annual meeting of the **National Tuberculosis Association** will be held in Los Angeles May 18-22, Dr. Joseph L. Robinson, president of the Los Angeles County Tuberculosis and Health Association, announced recently. This will be the first time in 15 years the organization has held its annual session in Los Angeles. The meeting closes only two days before the opening of the Annual Session of the California Medical Association, also to be held in Los Angeles.

Scheduled in conjunction with annual sessions of the American Trudeau Society and the National Conference of Tuberculosis Workers, the 49th national meeting of the Tuberculosis Association will have headquarters at the Statler and Biltmore hotels.

The **California Tuberculosis and Health Association** will conduct its annual meeting May 18 at 7 p.m. in the Statler Hotel.

"In addition to medical, nursing, program development and general sessions, an unusual program of entertainment has been planned," Dr. Robinson said.

SAN FRANCISCO

Two of the four lectures in the 71st course of **Popular Medical Lectures** sponsored by the Stanford University School of Medicine remain to be given. One is "Rehabilitation of the Polio Patient" by William H. Northway, M.D., which is scheduled for Friday, April 17, at 1:30 p.m. in Lane Hall; the other, "Sleep and Sleeping Pills," by Windsor C. Cutting, M.D., will be given April 27 at 1:30 in Lane Hall.

The first two lectures in the series were "Influenza: Past and Present" by Ernest Jawetz, M.D., and "How to Let Children Grow Up" by John A. Anderson, M.D.

* * * *

Dr. Robert Wartenberg, clinical professor of neurology, University of California Hospital, has been elected a corresponding member of the Rio de Janeiro Society of Neurology.

GENERAL

A luncheon for members of the **faculty and alumni of the University of California School of Medicine** will be held Monday, May 25, in the foyer of the Biltmore Bowl, Biltmore Hotel, Los Angeles. The date coincides with the first day of scientific sessions of the annual meeting of the California Medical Association, also to be held at the Biltmore.

Reservations for the luncheon may be obtained by writing to John M. Fernald, M.D., 3875 Wilshire Boulevard, Los Angeles 5.

* * * *

The program for the annual meeting of the **Pacific Coast Oto-Ophthalmological Society,** to be held May 24-May 28 in the Ambassador Hotel, Los Angeles, follows:

SUNDAY, MAY 24

9:00-5:00 p.m.—Registration.

5:00 p.m.—President's Reception.

MONDAY, MAY 25

9:00 a.m.—Presidential Address: Clifford Allen Dickey, M.D.

9:30 a.m.—Address by Guest Speaker for Otolaryngology: William James McNally, M.D., Montreal, Canada.

10:30 a.m.—Introduction to Guest of Honor (Eulogy to LeRoy Rich Pugmire, M.D., Ogden, Utah).
Business Meeting.

11:00 a.m.—Address by Guest Speaker for Ophthalmology: Olson E. Braley, M.D., Iowa City, Iowa.

TUESDAY, MAY 26

8:30 a.m.—Movie: Serous Otitis—H. B. Perlman, M.D., Chicago.

9:00 a.m.—Hereditary Hemorrhagic Telangiectasis — David A. Dolowitz, M.D., Salt Lake City.

9:30 a.m.—Laryngeal Stenosis — Marvin W. Simmons, M.D., Fresno.

10:00 a.m.—The Electro-Audiogram—Experiences with Objective Skin Resistance Audiometry—Victory Goodhill, M.D.; Seymour J. Brockman, M.D.; and Irving Rehman, Ph.D., Los Angeles.

10:30 a.m.—Round Table.

11:30 a.m.—Movie: An Otologic Seminar—H. G. Kobrak, M.D., Chicago.

WEDNESDAY, MAY 27

8:30 a.m.-5:00 p.m.—Instruction Courses.

THURSDAY, MAY 28

8:30 a.m.—Movie: Bronchography — James A. Harrill, M.D., Winston-Salem, N. C.
Discussion by Mervin C. Myerson, M.D., Beverly Hills.

9:00 a.m.—Changing Aspects of Bronchoesophagology—Thomas E. Douglas, Jr., M.D., Seattle, Wash.

9:30 a.m.—Modern Management of Facial Nerve Pathology—Merrill C. O'Donnell, M.D., Santa Monica.

10:00 a.m.—Transverse Incision in Pharyngeal Pulsion Diverticula—S. L. Perzik, M.D., Beverly Hills.

10:30 a.m.—Rhinoplastic Treatment of Recent Nasal Fractures—Lewis W. Jordan, M.D., Portland, Oregon.

11:00 a.m.—Clinico-Pathologic Studies of Obstruction of the Tear Passages—Richard Waldapfel, M.D., and Geno Saccomanno, M.D., Grand Junction, Colorado.

11:30 a.m.—Movie: Cardiac Arrest—Robert M. Hosler, M.D., Cleveland, Ohio.

* * * *

A 16-man advisory committee has been named to assist the California State Department of Public Health in developing a plan for the **distribution in California of gamma globulin** for the prevention of infantile paralysis. Dr. Wilton L. Halverson, state director of public health, said the advisory committee would meet as soon as it is known from the Office of Defense Mobilization the amount of gamma globulin California will receive and its policy for distribution. The Office of Defense Mobilization has the job of allocating the nation's current supply of gamma globulin to the 48 states.

The advisory committee has membership from the Cali-

fornia Medical Association, the California Osteopathic Association, the California Conference of Local Health Officers and other organizations and technical consultants, as follows:

Dr. Francis West, San Diego; Dr. H. Clifford Loos, Los Angeles, and Dr. Hollis Carey, Gridley, represent the Public Health Committee of the California Medical Association.

Dr. J. Gordon Epperson, Oakland, represents the California Osteopathic Association.

Dr. Roy O. Gilbert, Los Angeles County Health Officer; Dr. Henrik L. Blum, Contra Costa County Health Officer, and Dr. W. Elwyn Turner, Santa Clara County Health Officer, represent the California Conference of Local Health Officers.

Technical experts on the committee include Dr. Karl F. Meyer, director of the George William Hooper Foundation Medical Center, San Francisco; Dr. E. B. Shaw, of Children's Hospital, San Francisco; Dr. Walter Ward, associated with one of the laboratories which fractionates gamma globulin from whole blood, Berkeley, and Dr. A. G. Bower, Los Angeles County General Hospital.

Four members of the State Board of Health, Dr. Charles E. Smith, Berkeley; Dr. Samuel J. McClendon, San Diego; Dr. James R. Rinehart, San Francisco; and Dr. Harry E. Henderson, Santa Barbara, will also serve with the committee.

Dr. William P. Shepard, San Francisco, a member of the Health Resources Advisory Committee of the Office of Defense Mobilization, the branch of the ODM which is assigned the task of distributing gamma globulin, will meet with the California advisory committee.

* * * *

The 23rd annual meeting of the **Aero Medical Association** will be held at the Biltmore Hotel, Los Angeles, May 11, 12 and 13, 1953. Further information may be obtained from the secretary of the association, Thomas H. Sutherland, M.D., P.O. Box 26, Marion, Ohio.

* * * *

Attending the eighth **National Conference on Rural Health** held recently in Roanoke, Virginia, were Dr. Henry A. Randel of Fresno, chairman of the California Medical Association Committee on Rural Health, Dr. John Dement of Berkeley, chief of local health services of the California State Department of Public Health, Dr. J. Frank Doughty of Tracy, member of the A.M.A. Rural Health Committee, and Mrs. Ralph Eusden, president of the Woman's Auxiliary to the A.M.A.

* * * *

Women engaged in scientific research work in California will have an opportunity to win an award amounting to $1500 or more, it was announced today by Kappa Kappa Gamma sorority and the California Institute for Cancer Research.

Known as the Kappa Kappa Gamma Cancer Research Award, the newly created honor was established in memory of Mrs. Marion Howell Tompkins, a member of the sorority, it was stated by Louis H. Seagrave, chairman of the board of the Institute, and Mrs. E. Granville Crabtree, president of the sorority.

The award will be made for outstanding achievement in the field of cancer research, such as an important discovery or process, reported in the form of a scientific paper. A panel of three judges will determine the winning entry. Deadline for entries is July 1, 1953 and announcement of the award-winning paper will be made on September 30, 1953. Further information may be obtained from the California Institute for Cancer Research, 612 Flower Street, Los Angeles.

POSTGRADUATE EDUCATION NOTICES

MEDICAL EXTENSION UNIVERSITY OF CALIFORNIA

Postgraduate Courses for 1953

Pediatric Conference, June 22 through 26. Fee to be announced. Medical Center.

Conference on General Surgery, June 15 through 19. Fee $75.00. Medical Center.

Obstetrical and Gynecological Conference, September 2, 3, 4. Place and fee to be announced.

Ophthalmology (for specialists), September 14 through 19. Fee $75.00. Medical Center.

Medicine for General Practitioners, September through November. East Oakland Hospital. Fee $50.00.

Evening Lectures in Medicine, September through November. Fee $50.00. Mills Memorial Hospital, San Mateo (probably).

Contact: All inquiries to be addressed to Stacy R. Mettier, M.D., Professor of Medicine, Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22.

STANFORD UNIVERSITY SCHOOL OF MEDICINE

Cardiology—Date: June 15-19. Fee: $75.00.

General Medicine—Date: June 15-19. Fee: $75.00.

Surgery of Trauma—Date: June 22-26. Fee: $75.00.

General Surgery—Date: June 22-26. Fee: $75.00.

Programs and further information may be obtained from the Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15, California.

UNIVERSITY OF CALIFORNIA AT LOS ANGELES MEDICAL EXTENSION in cooperation with SCHOOL OF MEDICINE

Proctology Symposium—

Date: Thursday, April 16 (all day)—UCLA Campus.

Fee: $17.50.

Guest Speaker: J. Peerman Nesselrod, M.D., Chicago, Illinois.

Peripheral Vascular Diseases—

Date: Friday, April 17 (all day)—UCLA Campus.

Fee: $17.50.

Dermatology in General Practice—

Date: Wednesday afternoons, April 22 to May 27—UCLA Campus.

Fee: $30.00.

Techniques of Hypnosis—

Date: Friday evening and Saturday morning, May 8 to May 30—San Diego.

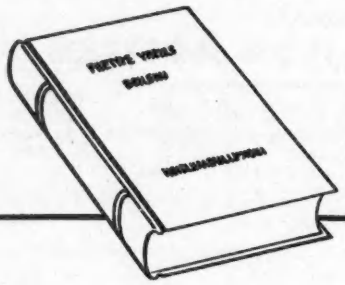
Fee: $100.00.

Laboratory Technicians' Symposium—

Date: June 20 and 21 (all day)—UCLA Campus.

Fee: $15.00.

Contact: Dr. Thomas H. Sternberg, Head of Postgraduate Instruction, Medical Extension, University of California, Los Angeles 24.



THE PHYSICIAN'S *Bookshelf*

MEDICAL LICENSURE EXAMINATIONS (Rypins')—Topical Summaries and Questions—7th Edition. Edited by Walter L. Bierring, M.D., F.A.C.P. J. B. Lippincott Company, Philadelphia, 1952. 856 pages, $8.00.

The seventh edition presents a compact and orderly review of 13 major medical subjects together with actual questions based on essential facts contained in the review of each subject.

This book, originally written by the late Harold Rypins, M.D., and revised three times by him, has been revised and brought up to date by a panel of medical teachers in a fifth, a sixth and now a seventh edition.

The table of contents is divided into two parts: Part One, Basic Medical Sciences, and Part Two, the Clinical Sciences.

In this latest revision, the title of the chapter on chemistry has been changed to "Biochemistry," and the chapter completely rewritten by a new author, Howard W. Robinson, M.D., Temple University School of Medicine. He has added more on carbohydrates, proteins and fats and their metabolism and has also included up-to-date information on the composition of individual body tissues, the chemistry of respiration, digestion, etc. There is a good new section on vitamins. A section on toxicology appearing in previous editions has been omitted.

There has been little change in the chapter on bacteriology except for a change of its title to "Microbiology" and the addition of a few new paragraphs on homologous serum jaundice, on coccidioidomycosis, and on histoplasmosis.

The chapter on hygiene and preventive medicine is now entitled "Preventive Medicine and Public Health" and written by the new authors Ernest L. Stebbins, M.D., and John C. Hume, M.D., Johns Hopkins School of Hygiene and Public Health. It is a well-organized outline of the subject in which all aspects of the field of public health are briefly and expertly reviewed.

Slightly revised discussions of the skin and of liver function and the added mention of antihormones, ACTH and the adrenals are included in the chapter on physiology.

Under the heading of pathology is to be found new information in outline form on virus pneumonia, collagen diseases, congenital heart disease, aneurysms and a few rare types of tumors.

The chapter on pharmacology has added newer knowledge on antibiotics, antihistamine compounds, chemotherapy, antimycotic agents, radioactive compounds, hormones, vitamins, autonomic drugs, etc.

The chapters on medicine and on surgery are very sketchy, but provide a good outline for the basis of study.

The chapter on psychiatry begins with a glossary of psychiatric terms that is very helpful to the student and then gives a short synopsis on the history, etiology and methods of therapy in psychiatry.

The publication contains considerable more material than the previous edition, but it has a good general index and subjects are easy to find. The editor is careful to avoid repetition and overlapping of subjects. There has been a deliberate omission of nearly all technical procedures.

This book is intended to assist both student and examiners. It affords an excellent basis for review of the subjects covered and therefore serves this purpose well.

The subject matter in most instances is well outlined with attention being paid to modern developments and concepts in medical knowledge. Actual questions based on the essential facts contained in each chapter serve the interests of the student by stimulating thought processes. The questions can also be of some assistance to the examiner in determining the type and scope of questions used in examinations.

This book will continue to occupy a useful place on every medical library shelf and has a definite value in preparation for all examinations in medicine. The student must understand its limitations, however. The fundamentals are given, but it is left to the student to supplement his review with the latest ever-changing current thinking and with some of the finer details in diagnosis and treatment.

* * *

OPHTHALMIC PATHOLOGY—An Atlas and Textbook. Jonas S. Friedenwald, Helenor Campbell Wilder, A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens, with the editorial assistance of Helen Knight Steward. Published under the joint sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. W. B. Saunders Company, Philadelphia, 1952. 489 pages, with 260 plates, $18.00.

As stated on the title page, the book was written by a group of leading American eye pathologists and was sponsored by the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. The book is divided into 18 chapters dealing with anatomic and physiologic considerations: Histology; growth and aging; nature and mechanism of inflammation; endophthalmitis; granulomatous inflammations; injuries; extrabulbar diseases; diseases of conjunctiva and cornea; diseases of the lens; intraocular fluid circulation, glaucoma and hypotony; diseases of the ocular blood vessels; retina, disc and optic nerve; congenital and developmental anomalies; prenatal and neonatal diseases; heredofamilial and degenerative diseases, and tumors.

A successful attempt is made, where the present status of progress permits, to correlate morphological pathology with the physiological and biochemical pathology. Antiquated and frequently confused terms are clearly defined and classified into modern terminology. The text of each chapter is followed by an adequate reference list and the index is comprehensive.

The illustrations at the end of each chapter are all excellent photomicrographs, well labeled and beautifully printed, and will be of exceptional value especially to those without

access to a large eye pathology collection. One criticism that has been made is that the illustrations are not tied into the text. If this had been done it is obvious that the book could not be sold for its present sale price, which incidentally is very reasonable for such a book.

As this is a first edition there are occasional errors of fact which will undoubtedly be corrected in future editions.

The format is excellent; the paper good, the printing easily legible and, as already stated, the illustrations are beautifully printed.

The aim of the committee was "to provide a text embodying the requirements in histopathology for Board certification, to further instruction of residents in hospitals with limited teaching and laboratory facilities, and to furnish a convenient course for the ophthalmologist pursuing study in the pathology of his specialty." However, the volume must be considered not a substitute for the actual study of microscopic slides but an important adjunct to the study of the slides.

The book succeeds admirably in its aim and is recommended without reservation.

* * *

PROGRESS IN FUNDAMENTAL MEDICINE. Edited by J. F. A. McManus, M.D., University of Virginia, with ten outstanding contributors. Lea & Febiger, Philadelphia, 1952. 316 pages, 74 illustrations and 2 plates in color, $9.00.

This volume consists of a series of essays on "topics of current clinical and pathologic importance." The subjects were chosen, according to the editor, "because information is being added about them" and were gathered together in a volume because of the view that newer material as published in scientific journals or in textbooks "may fail to reach the attention of some doctors." This point of view is not shared by the present reviewer.

The volume is physically attractive and the discussions, written by contributors to the field in each case, are generally good. That on pathology of systemic lupus erythematosus by Klemperer is outstanding. Other subjects concern protein hydrolysates and other aspects of parenteral nutrition (Cannon), the liver (G. K. and T. B. Mallory), coronary artery disease (Paterson), non-silica pneumonoconioses (Wyatt), melanotic tumors of the skin (Cunningham), carcinoma in situ of the cervix uteri (Stoddard and Cuyler), the diagnosis of fungus infections with particular reference to staining methods (Kligman), and a survey of techniques for the histochemical approach to pathology (McManus). The discussions emphasize pathological aspects but include clinical ones as well. Each offers a list of references. There is a general index.

* * *

DISEASES OF THE SKIN—A Manual for Students and Practitioners. First compiled by the late Robert W. MacKenna, M.A., M.D., Ch.B. (Edin.). **Fifth Edition** compiled by Robert M. B. MacKenna, M.A., M.D. (Camb.), F.R.C.P. (Lond.), Physician-in-Charge of the Dermatological Department and Lecturer in Dermatology, St. Bartholomew's Hospital and Medical College, London. Distributed by Williams and Wilkins Co., Baltimore, 1952. 611 pages, $8.00.

The fifth edition of this time-honored British text has been brought thoroughly up to date. It is well illustrated with numerous black-and-white and colored photographs of excellent quality. It can be highly recommended. However, one of the standard American texts would probably be preferable for undergraduate students in the United States schools.

The dosage of superficial x-ray therapy recommended for certain benign conditions (for example, flat warts of the face and hemangiomas) would be considered dangerously high by most American dermatologists.

The omission of a bibliography makes the book less valuable as a reference.

KITCHEN STRATEGY—The Family Angle on Nutrition. Leona M. Bayer, M.D., Assistant Clinical Professor of Medicine, Stanford University School of Medicine; and Edith Green, Television Cooking Expert, San Francisco. Charles C. Thomas, Publisher, Springfield, 1952. 94 pages, $3.75.

The authors have assembled basic and pertinent information on nutrition and have oriented it in a practical fashion for the homemaker upon whom the success of a therapeutic dietary prescription rests. There is much useful information for those who are interested in feeding a family intelligently, well, and economically, and at the same time meeting the prescriptive requirements of a sick member of the family. The information is interestingly presented and is easy to comprehend. The menus for the common illnesses are simple and helpful, and should be welcome not only to the homemaker but also to the physician. It is the mutual understanding between these two which insures the proper care for the patient who must adhere to a nutritional dietary program.

The table of menu planning in which the simple food for the child is altered in a more palatable form for the more sophisticated members of the family is full of helpful suggestions. The last half of the book is devoted to recipes and suggestions designed to add interest to the dietary routine of menus.

This book could be recommended to housewives, since it brings together much information, which although available perhaps elsewhere, here carries the authority of a physician.

* * *

SURGERY OF THE EYE—Third Revised Edition. Meyer Wiener, M.D., Emeritus Professor of Clinical Ophthalmology, Washington University School of Medicine; and Harold G. Scheie, M.D., D.Sc., F.A.C.S., Associate Professor of Ophthalmology, the Medical School and Hospital, and Assistant Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania. Grune and Stratton, New York, 1952. 449 pages, $15.00.

This book is a revised third edition of 449 pages and 15 chapters. The preface describes the changes in the book. The book is very readable and has good illustrations. The chapter on basic techniques in ophthalmic surgery is very good. The chapter on cataract surgery outlining the various types of sections, closures and extraction techniques is exceptionally good. The chapter on glaucoma upon which Dr. Scheie has done outstanding work is very thorough, clear cut and specific.

This book is a good supplement to our present books on surgery.

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THE JOURNAL OF THE AMERICAN GERIATRICS SOCIETY. Published monthly by the Williams & Wilkins Company, Baltimore, Md. $10.00 per year.

In January 1953 appeared Volume 1, Number 1 of the *Journal of the American Geriatrics Society*. Willard O. Thompson, M.D., the editor, feels that the problems of our steadily enlarging aged population justify the establishing of another publication in the new specialty of geriatrics. The founder and secretary of the society, Malford W. Thewlis, M.D., suggests that we come within the scope of the geriatrician at 40, an age these days scarcely on the horizon of middle age. It is the intention of the editor to present clinical studies of geriatric problems, and the first issue contains excellent articles on some disorders of the aged in the fields of medicine, surgery, urology, gynecology, radiology, otorhinolaryngology and psychiatry. There is a section of abstracts of current geriatric literature. Aside from considerations as to whether or not this new journal fills a need, the format is attractive and the material nicely arranged and presented.

Hotel Reservation

FOR C.M.A. ANNUAL SESSION

IF YOU HAVE NOT already notified the C.M.A. office of the hotel accommodations you would like to have for the Annual Session, May 24 through 28, won't you order your reservation now? Just complete the form below and send it to the main office, 450 Sutter Street, San Francisco, at the earliest possible date—not later than May 1, please. A hotel assignment notice will be sent to you upon receipt of the completed form.

	Single	*Double*	*Twin Beds*	*Triple*	*Suites*
BILTMORE HOTEL	$5.50	$8.50	$9.00	$2.50	$17-20
515 S. Olive	11.50	14.00	14.00	per person extra	22-25 26-33
GAYLORD HOTEL	7.00	9.50	9.50	10.00	13.50
3355 Wilshire	and up	and up	and up	and up	and up
MAYFLOWER HOTEL	5.25	5.25	5.75	7.75	14.00
535 S. Grand Ave.	8.00	8.00	9.00		
TOWN HOUSE	9-15	12-18	12-18	3.00	22.00
639 Commonwealth				per person extra	and up
ALEXANDRIA HOTEL	4.00	6.00	7.00	2.00	12.50-25
210 West Fifth St.	8.00	9.00	10.50	per person extra	

Please fill out and return this blank not later than May 1

CALIFORNIA MEDICAL ASSOCIATION
450 Sutter Street — Room 2000
San Francisco 8, California

Gentlemen:

Please make hotel reservations for me at the.....Hotel

in Los Angeles (second choice: .....) for the period of the C.M.A. Annual Session, as follows:

Single Room $.....Double Room $.....Twin-Bed Room $.....

Parlor (large/small) Suite $.....Adjoining Twin-Bed Rooms, No..... $.....

Number in party is....., consisting of self and .....

Will arrive (date)....., ...A.M. or .....P.M.

Will depart (date)....., ...A.M. or .....P.M.

PRINT NAME PLEASE

NAME.....

ADDRESS.....

CITY.....COUNTY.....

CALIFORNIA MEDICAL ASSOCIATION

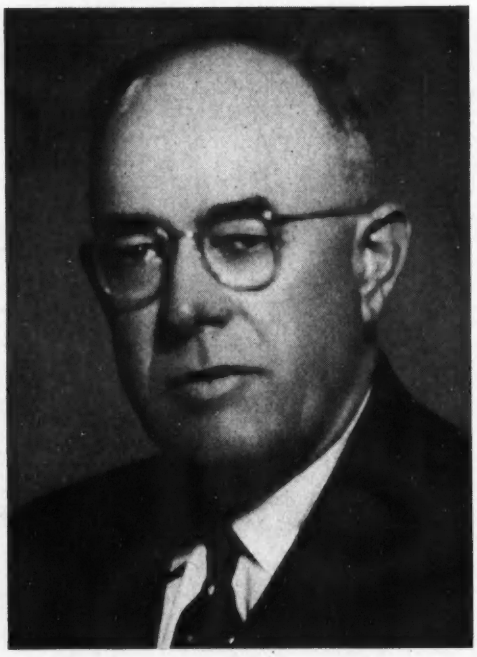
82nd Annual Session

Los Angeles, May 24-28, 1953

Scientific Sessions

Meetings of the House of Delegates

LEWIS A. ALESEN
President



JOHN W. GREEN
President-Elect

PROGRAM AND PRE-CONVENTION REPORTS

for the

CALIFORNIA MEDICAL ASSOCIATION

Eighty-Second Annual Session

Los Angeles, May 24-28, 1953

Biltmore Hotel

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PRE-CONVENTION REPORTS

Cancer Commission Pre-Convention Conferences, Page 340

C.M.A. Cancer Commission
Pre-Convention Conference

LOS ANGELES—SATURDAY, MAY 23

Radiology

Conference Room 1, Biltmore Hotel

Chairman.....Joseph F. Linsman, M.D., Los Angeles
Secretary.....Charles E. Duisenberg, M.D., Palo Alto

DIAGNOSTIC SESSION—9:30 a.m. to Noon

1. Bone Lesion ..... George Jacobson, M.D.
2. Pediatric Bone Lesion..... Bernard O'Laughlin, M.D.
3. Bone Lesion ..... Ivan Miller, M.D.
4. Pediatric Skull Lesion..... Harvey Humphrey, M.D.
5. Skull Lesion ..... Evelyn Siris, M.D.
6. Bone Lesion with Response to Cortisone..... Norman N. Keef, M.D.
7. Chest Lesion ..... John B. Hamilton, M.D., and Walter Stilson, M.D.
8. Lung Lesion ..... M. A. Sisson, M.D.
9. Heart Case ..... William W. Saunders, M.D.
10. Heart Case ..... William L. Anderson, M.D.
11. Gastrointestinal Lesion ..... Eugene Freedman, M.D.
12. Neurological Lesion ..... John Camp, M.D.

THERAPY SESSION—2:00 p.m. to 4:30 p.m.

1. Treatment of a Skin Carcinoma Recurrent After Irradiation ..... Richard A. Shepard, M.D.
2. High-Voltage X-Ray Treatment of a Bladder Tumor..... Eugene G. Tainter, M.D.
3. Carcinoma of the Bladder..... Henry Jaffe, M.D.
4. Reticulum Cell Sarcoma of Bone..... Harold Tompkins, M.D.
5. Carcinoma of Cervix..... James F. Nolan, M.D.

Pathology

Auditorium, Los Angeles County Medical Association Building,
1925 Wilshire Boulevard

The Pre-Convention Conference on Microscopic Tumor Pathology will be held from 9:30 a.m. to 12 noon and from 2 to 4 p.m. under the chairmanship of Dr. Sidney Madden, Professor of Pathology, U.C.L.A. School of Medicine. Dr. Louisa E. Keasbey, Los Angeles, will be the moderator. Dr. Keasbey's subject will be "Tumors of the Salivary Gland, Skin Adnexa and Breast." Members who attend this conference are requested to register now with Dr. E. M. Hall, Tumor Tissue Registry, C.M.A. Cancer Commission, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33.

6:30 p.m.—Hotel Statler

Dinner Meeting of the California Society of Pathologists. Guest Speaker: John R. Schenken, M.D., Professor of Pathology, University of Nebraska. For reservations contact H. Russell Fisher, M.D., secretary, 500 South Lucas Avenue, Los Angeles 17.

6:00 p.m.—Conference Room 3, Biltmore Hotel

Dinner Meeting of the Cancer Commission and Advisory Committee

Information

BADGES. It is important that badges be worn at all times. Admission to scientific meetings is by badge only.

COUNCIL. The first meeting of the Council will be held Saturday, May 23, at 9:30 a.m., Biltmore Hotel. Further meetings will be held each morning at 7:30 a.m. in Conference Room 6, Biltmore Hotel.

DELEGATES. For a list of delegates, meeting times and places, see Pages 378 to 382 of this program.

EMERGENCY CALLS AND MESSAGES. Each physician should notify his own secretary regarding the *exact* section he plans to attend and the time of his attendance. It is up to the individual physician to keep his own office staff so informed. The Association will attempt to transmit messages to the individual physician *when* these are delivered to the Information Desk, Ballroom, at the south end of the Galeria, with the information concerning the exact location of the prospective recipient of the message.

In cases of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, DUnkirk 7-7175; Sunday and evenings after 5:00 p.m., DUnkirk 7-8141.

EXHIBITS. Technical Exhibits are in the Ballroom, Ballroom Foyer and Music Room. See list on Pages 369 to 377.

Scientific Exhibits may be seen in the North and Main Galeria. See list on Page 365.

Medical Motion Pictures will be shown daily in the Galeria Room. For schedule see Pages 365 to 367.

You are urged to visit and attend all exhibits.

MEETING TIMES AND PLACES. See chart on Page 343 for exact times and places of general and sectional meetings.

PRESIDENT'S DINNER DANCE. The Annual President's Dinner Dance will be held Monday night, May 25 in the Biltmore Bowl, at 7:30 p.m. Tickets are on sale at the Registration Desk. Formal dress is optional.

REGISTRATION AND INFORMATION

Registration and information desks are located in the Ballroom at the south end of the Galeria of the Biltmore Hotel. ALL MEMBERS, GUESTS, AND VISITORS are requested to register immediately on arrival. There is no charge for registration. Registration desks are open from 9:00 a.m. to 5:00 p.m. daily. ADMISSION TO THE GENERAL AND SECTION SESSIONS AND EXHIBIT AREAS IS BY BADGE ONLY.

Entertainment

1. **Annual President's Dinner,** Monday, May 25, Biltmore Bowl. Please secure tickets early.

2. **The Annual Golf Tournament** will be held Tuesday afternoon, May 26, at the Wilshire Country Club. All members attending the meeting are welcome to play. Tee off time 10 a.m. on. Numerous prizes will be awarded. No reservations are necessary. For further information contact W. L. Roberts, M.D., Secretary, Southern California Medical Golf Association, 727 W. Seventh Street, Los Angeles; telephone TUcker 2417.

3. **California Society of Allergy Reception and Dinner,** Tuesday, May 26, Conference Room 2; Luncheon, Tuesday, May 26, Bowl Foyer. For information and reservations contact Elizabeth Sirmay, M.D., 133 S. Lasky Drive, Beverly Hills.

4. **U.C. Medical School Alumni Association Luncheon,** Monday, May 25. For information and reservations contact John Fernald, M.D., 3875 Wilshire Boulevard, Los Angeles.

WOMEN'S ENTERTAINMENT — Tickets available for TV and radio broadcasts for members and guests. Inquire at Woman's Auxiliary table marked **Entertainment** located in the Main Galeria.

Reception honoring Mrs. Lewis A. Alesen, Monday, May 25, 4:00 to 6:00 p.m., Rendezvous Room, Biltmore Hotel.

Other Meetings — Ancillary Organizations

WEDNESDAY, MAY 27

American College of Chest Physicians—California Chapter—Conference Room 1, Biltmore Hotel, 9:30 a.m. to 5:00 p.m.

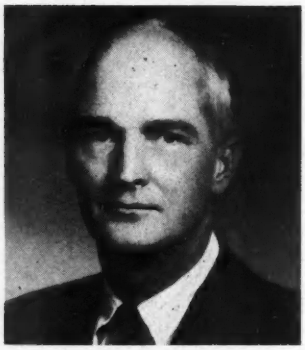
California Heart Association—Auditorium, Southern California Edison Building, 2:00 p.m. to 5:00 p.m.

Conference of Local Health Officers—Auditorium, Sunkist Building, 9:30 a.m. to 5:00 p.m.

Pacific Coast Oto-Ophthalmological Society Annual Meeting—Ambassador Hotel.

Guest Speakers

CLARENCE MANION



JOHN H. GIBBON, JR.

JOHN H. TALBOTT

RICHARD A. KERN

EDGAR BURNS

Guest Speakers

CLARENCE MANION, J.D., South Bend, Indiana—Formerly Dean, University of Notre Dame College of Law, and Founder of the Natural Law Institute at the University of Notre Dame.

JOHN H. GIBSON, JR., M.D., Philadelphia, Pennsylvania—Professor of Surgery, Jefferson Medical College.

JOHN H. TALBOTT, M.D., Buffalo, New York—Professor of Medicine, University of Buffalo School of Medicine.

RICHARD A. KERN, M.D., Philadelphia, Pennsylvania—Professor of Internal Medicine, Temple University School of Medicine.

EDGAR BURNS, M.D., New Orleans, Louisiana—Professor of Urology, Tulane University of Louisiana School of Medicine.

Other Section Speakers From Out of State

HINTON D. JONEZ, M.D., Tacoma, Washington—Guest of Section on Allergy.

JOHN H. MOYER, M.D., Houston, Texas—Professor of Pharmacology, Baylor University School of Medicine. Guest of Section on General Medicine.

JOHN R. SCHENKEN, M.D., Omaha, Nebraska—Professor of Pathology, University of Nebraska College of Medicine. Guest of Section on Pathology and Bacteriology.

ERNEST L. STEBBINS, M.D., Baltimore, Maryland—Dean, School of Hygiene and Public Health, Johns Hopkins University School of Medicine. Guest of Section on Public Health.

ARNOLD P. FRIEDMAN, M.D., NAOMI DE SOLA POOL, M.D., and THEODORE J. C. VON STORCH, M.D., New York, New York—Neurological Institute. Guests of Section on Psychiatry and Neurology.

SCIENTIFIC SESSIONS

	SUNDAY MAY 24 *All Day*	MONDAY MAY 25 A.M.	MONDAY MAY 25 P.M.	TUESDAY MAY 26 A.M.	TUESDAY MAY 26 P.M.	TUESDAY MAY 26 *Evening*	WEDNESDAY MAY 27 *All Day*	THURSDAY MAY 28 A.M.	THURSDAY MAY 28 P.M.
BILTMORE HOTEL Biltmore Bowl						**8:00 p.m. General Meeting Open to Public**			
Renaissance Room	**9:30 a.m. House of Delegates**	**9:30** General Practice	**1:30** General Meeting and Clinical-Pathological Conference	**9:30** Pediatrics	**2:00** General Surgery General Medicine Radiology		**9:30 a.m. House of Delegates**	**9:30** General Medicine	**2:00** Public Health General Practice Pathology and Bacteriology Pediatrics
Conference Room 1		**9:30** Radiology		**9:30** Radiology	**2:00** Pediatrics	**8:00 p.m. General Meeting Open to Public Biltmore Bowl**		**9:30** Psychiatry and Neurology	**2:00** Psychiatry and Neurology
Conference Room 2		**9:30** Industrial Medicine and Surgery			**2:00** Eye, Ear, Nose and Throat			**9:30** Obstetrics and Gynecology	**2:00** Obstetrics and Gynecology
Conference Room 4				**9:30** Urology	**2:00** Urology				
Conference Room 5				**9:30** Allergy	**2:00** Allergy				
Conference Room 8		**9:30** Pathology and Bacteriology	**2:00** Pathology Bacteriology		**2:00** Anesthesiology				
GALERIA ROOM		**9:00 a.m. to 5:30 p.m. Medical Motion Pictures**		**9:00 a.m. to 5:30 p.m. Medical Motion Pictures**			**9 a.m. to 5:30 p.m. Medical Motion Pictures 7 p.m. to 11:00 p.m.**	**9:00 a.m. to 4:00 p.m. Medical Motion Pictures**	
BAPTIST CHURCH CHAPEL Fifth and So. Olive								**9:30** General Practice	
SO. CALIFORNIA EDISON BLDG. Fifth and So. Grand		**9:30** General Surgery		**9:30** General Medicine	**2:00** Industrial Medicine and Surgery General Practice	**8:00 p.m. General Meeting Open to Public Biltmore Bowl**		**9:30** General Surgery	
SUNKIST BUILDING Fifth and So. Flower		**9:30** Urology Pediatrics		**9:30** Dermatology and Syphilology	**2:00** Dermatology and Syphilology			**9:30** Public Health	

COUNCIL OF THE C.M.A. MEETS DAILY AT 7:30 A.M. IN CONFERENCE ROOM 6, BILTMORE HOTEL

SCIENTIFIC EXHIBITS—North and Main Galerias, Biltmore Hotel

TECHNICAL EXHIBITS—Music Room, Ballroom, and Ballroom Foyer, Biltmore Hotel

HOUSE OF DELEGATES meets Sunday and Wednesday, 9:30 a.m.

MEDICAL MOTION PICTURES—Galeria Room, Biltmore Hotel

SCIENTIFIC SESSIONS

General Meetings

FIRST GENERAL MEETING

MONDAY, MAY 25

1:30—Renaissance Room, Biltmore Hotel

Chairman: Lewis A. Alesen, M.D., Los Angeles

1:30—**Address of Welcome** — Paul Foster, M.D., President, Los Angeles County Medical Association.

1:35—**Greetings from the Woman's Auxiliary**—Mrs. Raleigh W. Burlingame, President, Woman's Auxiliary to the California Medical Association.

1:40—**Sarcoidosis**—John H. Talbott, M.D., Buffalo, N. Y., by invitation.

2:00—**Unilateral Renal Disease and Hypertension**—Edgar Burns, M.D., New Orleans, La., by invitation.

2:30—**The Contribution of the Investigator to the Development of Modern Surgery** — John H. Gibbon, Jr., M.D., Philadelphia, Pa., by invitation.

3:00—**The Growing Problem of Suicide**—Richard A. Kern, M.D., Philadelphia, Pa., by invitation.

3:30—**Recess.**

Clinical-Pathological Conference

Moderator: L. Henry Garland, M.D., San Francisco

3:40—**Case No. 1**—Pathologist, Hugh A. Edmondson, M.D., Los Angeles. Surgeon, John H. Gibbon, Jr., M.D., Philadelphia, Pa., by invitation.

4:20—**Case No. 2**—Pathologist, Alvin J. Cox, M.D., San Francisco. Clinician, John H. Talbott, M.D., Buffalo, N. Y., by invitation.

SECOND GENERAL MEETING

Open to the Public

TUESDAY EVENING, MAY 26

8:00—Biltmore Bowl, Biltmore Hotel

8:00—**Introductory Remarks** — Lewis A. Alesen, M.D., Los Angeles.

8:05—**Blueprint for Freedom** — Clarence Manion, J.D., South Bend, Ind., by invitation.

EMERGENCY CALLS

Notify your office or exchange regarding the meetings you plan to attend. In cases of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, DUnkirk 7-7175; Sunday and evenings after 5:00 p.m., DUnkirk 7-8141.

ADMISSION TO SESSIONS AND EXHIBITS BY REGISTRATION BADGE ONLY

Section Meetings

GENERAL MEDICINE

Chairman.....J. Malcolm Stratton, M.D., Berkeley
Secretary.....William D. Evans, M.D., North Hollywood
Assistant Secretary.....Edgar Wayburn, M.D., San Francisco

J. MALCOLM STRATTON
Chairman

WILLIAM D. EVANS
Secretary

TUESDAY, MAY 26

9:30—Auditorium, Southern California Edison Building

9:30—**Methionine Metabolism in Patients with Hepatic Damage**—Harry E. Balch, M.D., Oakland.

9:45—**Systemic Lupus Erythematosus**—Edmund L. Dubois, M.D., Beverly Hills.

10:00—**Advances in the Treatment of Infectious Diseases with Antimicrobial Drugs**—H. Corwin Hinshaw, M.D., San Francisco.

10:15—**Long Term Therapy of Rheumatoid Arthritis with Cortisone**—Ephraim P. Engleman, M.D., San Francisco.

10:30—**The Recognition of Gout**—Alexander G. Bartlett, M.D., San Francisco.

10:40—Recess.

10:45—**Phenylbutazone—An Evaluation of Its Use**—Willard G. Snow, M.D., San Francisco.

10:55—**Recent Advances in the Understanding of the Metabolism of Uric Acid as Determined by Isotope Studies**—John H. Talbott, M.D., Buffalo, N. Y., by invitation.

11:25—**Round Table Discussion—Gout and Arthritis.**

Moderator: John H. Talbott, M.D., Buffalo, N. Y., by invitation.

Members of the Panel: Ephraim P. Engleman, M.D., Alexander G. Bartlett, M.D., and Peter H. Forsham, M.D., San Francisco.

TUESDAY, MAY 26

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with Sections on General Surgery and Radiology

Symposium on Diseases of the Esophagus

For program, see Section on General Surgery.

THURSDAY, MAY 28

9:30—Renaissance Room, Biltmore Hotel

Symposium

Hypotensive Drugs

9:30—**The Clinical Evaluation of Hydergine (C.C.K. 179) in Arterial Hypertension**—Ralph M. Tandowsky, M.D., Los Angeles.

9:40—**Outpatient Treatment of Fifteen Hypertensive Patients with Orally Administered Hexamethonium Salts and Apresoline**—Laurence J. Stuppy, M.D., Los Angeles.

9:50—**The Use of Apresoline Compared with the Use of Placebos in the Treatment of Hypertensive Diseases**—David H. Merrill, M.D., Los Angeles.

10:00—**Rauwolfia Serpina—A New Drug for the Therapy of Essential and Malignant Hypertension**—Meyer Friedman, M.D., San Francisco.

10:10—**The Use of Hexamethonium in Arterial Hypertension**—David A. Rytand, M.D., San Francisco.

10:25—Recess.

10:30—**Round Table Discussion.**

Moderator: John H. Talbott, M.D., Buffalo, N. Y., by invitation.

Members of the Panel: Ralph M. Tandowsky, M.D., Laurence J. Stuppy, M.D., and David H. Merrill, M.D., Los Angeles; Meyer Friedman, M.D., San Francisco; and John H. Moyer, M.D., Houston, Texas, by invitation.

11:25—**Business Meeting and Election of Officers.**

11:30—**Diffuse Collagen Diseases**—John H. Talbott, M.D., Buffalo, N. Y., by invitation.

GENERAL SURGERY

Chairman . . . . . Paul C. Samson, M.D., Oakland
Secretary . . . . . Arthur C. Pattison, M.D., Pasadena
Assistant Secretary . . . . . William Brock, M.D., Stockton

PAUL C. SAMSON
Chairman

ARTHUR C. PATTISON
Secretary

MONDAY, MAY 25

9:30—Auditorium, Southern California Edison Building

Symposium

Nutrition and Electrolytes

9:30—**Introductory Remarks—Grams Per Cent vs. Milliequivalents** — Milton M. Ashley, M.D., Beverly Hills.

9:40—**Maintenance Nutritional Requirements of the Surgical Patient**—Richard E. Gardner, M.D., San Francisco, and Harold A. Harper, Ph.D., by invitation, San Francisco.

9:55—**The Kidney — Master Controller of Fluid-Electrolyte Balance**—Richards P. Lyon, M.D., Oakland, by invitation.

10:10—**The Importance of Sodium in the Surgical Patient**—S. Austin Jones, M.D., Los Angeles, by invitation.

10:25—**The Importance of Potassium in the Surgical Patient**—George C. Henegar, M.D., Oakland.

10:40—**The Management of Difficult Water and Electrolyte Problems in Surgical Practice with the Use of Water and Electrolyte Balance Sheet**—H. H. Belding III, M.D., Riverside.

10:55—**Treatment of Refractory Shock**—Edward N. Snyder, M.D., Pasadena.

11:10—**Some Comments on Convalescence Following Major Operations**—John H. Gibbon, Jr., M.D., Philadelphia, Pa., by invitation.

11:40—**Question and Answer Period.**

TUESDAY, MAY 26

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with the Sections on General Medicine and Radiology

Symposium

Diseases of the Esophagus

2:00—**The Medical Aspects of Esophageal Disease**—Dwight L. Wilbur, M.D., San Francisco.

2:25—**The Esophagus in Radiologic Problems**—Robert K. Arbuckle, M.D., Oakland, Chairman, Section on Radiology.

2:45—**Injuries and Wounds of the Esophagus: Their Diagnosis and Treatment**—Paul C. Samson, M.D., Oakland, Chairman, Section on General Surgery.

3:05—**The Non-Surgical Management of Esophagitis, Peptic Ulcer and Early Stricture**—William L. Rogers, M.D., San Francisco.

3:25—**The Surgical Treatment of Carcinoma of the Esophagus**—John H. Gibbon, Jr., M.D., Philadelphia, Pa., by invitation.

3:50—**Recess.**

4:00—**Round Table Discussion.**

Moderator: John H. Gibbon, Jr., Philadelphia, Pa., by invitation.

Members of the Panel: Dwight L. Wilbur, M.D., San Francisco; Robert K. Arbuckle, M.D., Oakland; and William L. Rogers, M.D., San Francisco.

(Continued on next page)

THURSDAY, MAY 28

9:30—Auditorium, Southern California Edison Building

9:30—**Intestinal Intubation—Its Use and Abuse**—Louis Sperling, M.D., Beverly Hills.

9:50—**Mechanical Bowel Obstruction Due to Inflammatory Conditions** — Milton Gordon, M.D., Bakersfield.

10:10—**Rupture of the Gastrointestinal Tract Due to Non-Penetrating Trauma**—Howard Kirtland, Jr., M.D., San Diego.

10:30—**Traumatic Pancreatitis**—Clarence J. Berne, M.D., Los Angeles, and Robert L. Walters, M.D., by invitation, Los Angeles.

10:50—**Observations on the Nature of the Solitary Pulmonary Lesion**—Ivan A. May, M.D., Oakland.

11:10—**Business Meeting and Election of Officers.**

11:20—**Present Concepts in the Management of Peripheral Arteriosclerosis** — Edwin J. Wylie, M.D., San Francisco.

11:40—**Lumbar Sympathectomy in the Older Age Groups**—Herbert J. Movius II, M.D., Long Beach, by invitation.

12:00—**Vasospastic Disorders of the Extremities Associated with Injury**—Vance M. Strange, M.D., San Francisco.

EMERGENCY CALLS AND MESSAGES

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No outside phone calls will be permitted from the telephone located at the Information Desk. Pay telephones are located in the Main Galeria and in the lower lobby of the hotel, near the travel agency office.

GENERAL PRACTICE

Chairman . . . . . Merlin L. Newkirk, M.D., Santa Ana
Secretary . . . . . A. Bradford Carson, M.D., Oakland
Assistant Secretary . . . . . Joseph W. Telford, M.D., San Diego

MERLIN L. NEWKIRK
Chairman

A. BRADFORD CARSON
Secretary

MONDAY, MAY 25

9:30—Renaissance Room, Biltmore Hotel

9:30—**Saving Maternal and Neonatal Lives**—James W. Ravenscroft, M.D., San Diego.

10:00—**The Management of Premature Labor**—E. W. Cartwright, M.D., Pasadena.

10:30—**An Evaluation of Factors in Obstetrical Analgesia**—Harry S. Fist, M.D., Los Angeles.

11:00—**The Management and Mismanagement of Breech Presentation**—A. C. Mietus, M.D., Los Angeles.

11:30—**Practical Considerations in the Management of Allergic Patients**—Richard A. Kern, M.D., Philadelphia, Pa., by invitation.

TUESDAY, MAY 26

2:00—Auditorium, Southern California Edison Building

Joint Meeting with the Section on Industrial Medicine and Surgery

For program, see Section on Industrial Medicine and Surgery.

THURSDAY, MAY 28

9:30—Chapel, Baptist Church

9:30—**Chronic Brucellosis: A Common Dilemma for Practitioners**—Joseph F. Griggs, M.D., Claremont.

10:00—**Dizziness, Vertigo and Syncope**—Kurt Gunther, M.D., Santa Barbara, and Roy Swartout, III, M.D., El Monte.

10:30—**Management of Postoperative Distention**—Edward B. Dewey, M.D., Pasadena.

11:00—**Differential Diagnosis of Cecal and Pericecal Lesions**—Richard E. Ottoman, M.D., Los Angeles, by invitation; and John H. Woodruff, M.D., Huntington Park.

11:30—**Business Meeting.**

THURSDAY, MAY 28

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with the Sections on Public Health, Pediatrics, Pathology and Bacteriology.

Symposium on Encephalitis

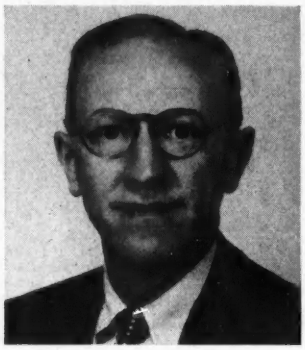
For program, see Section on Public Health.

VISIT THE TECHNICAL AND SCIENTIFIC EXHIBITS

ALLERGY

Chairman.....M. Coleman Harris, M.D., San Francisco
Vice-Chairman.....Grace M. Talbott, M.D., San Francisco
Secretary.....Norman Shure, M.D., Los Angeles

M. COLEMAN HARRIS
Chairman



NORMAN SHURE
Secretary

TUESDAY, MAY 26

9:30—Conference Room 5, Biltmore Hotel

9:30—**Failure of Tyrosine-Niacinamide-Pyridoxine Mixture to Influence Allergic Disease**—Walter R. MacLaren, M.D., Pasadena; Ben C. Eisenberg, M.D., and David M. Goldstein, M.D., Beverly Hills.
Discussion.

10:00—**A Clinical and Physiological Appraisal of Dyspnea**—Walter E. Macpherson, M.D., Los Angeles.
Discussion.

10:30—**Chairman's Address: The Practice of Allergy—1953**—M. Coleman Harris, M.D., San Francisco.

11:15—**The Allergic Aspects of Multiple Sclerosis**—Hinton D. Jonez, M.D., Tacoma, Wash., by invitation.
Discussion.

12:00—**Luncheon Meeting**—The California Society of Allergy—Bowl Foyer.

TUESDAY, MAY 26

2:00—Conference Room 5, Biltmore Hotel

2:00—**Transient Markedly Elevated Local Pollen Counts: Is This a New Trend in California?**—John S. O'Toole, M.D., Riverside.
Discussion.

2:30—**Advances in the Treatment of Asthma in the Light of Current Medical Knowledge**—Hyman Miller, M.D., Beverly Hills.
Discussion.

3:00—**Diagnostic Problems of Cephalalgia**—Ralph Bookman, M.D., Los Angeles.
Discussion.

3:30—**Further Studies on the Use of Raw Foods as Skin Testing Material in Allergic Disorders**—Giacomo R. Ancona, M.D., and Irwin Schumacher, M.D., San Francisco.
Discussion.

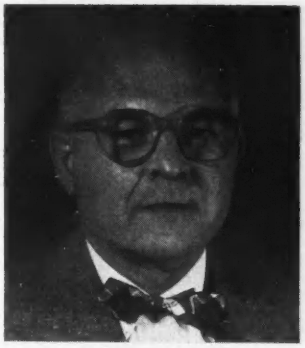
4:00—**Experiences with Piromen in the Treatment of Allergic Disorders**—Granville F. Knight, M.D., Santa Barbara.
Discussion.

VISIT THE TECHNICAL AND SCIENTIFIC EXHIBITS

ANESTHESIOLOGY

Chairman.....Nevin H. Rupp, M.D., Los Angeles
Secretary.....Joseph H. Failing, M. D., San Marino
Assistant Secretary.....Marshall L. Skaggs, M.D., San Francisco

NEVIN H. RUPP
Chairman



JOSEPH H. FAILING
Secretary

TUESDAY, MAY 26

2:00—Conference Room 8, Biltmore Hotel

Panel Discussion

Intravenous Therapy

Moderator: Edward B. Tuohy, M.D., Los Angeles.

Members of the Panel: John B. Dillon, M.D., Pasadena; Frank J. Murphy, M.D., San Francisco; Desiderio A. Roman, M.D., Los Angeles, and Ernest H. Warnock, M.D., San Marino.

The panel discussion will be concerned with clinical use of any kind of medication that is given intravenously—glucose, blood, molar lactate, Pentothal, Surital, morphine, Demerol, Pantopon, Nalline, Tubocurarine, Syncurine, Succinylcholine, Tensilon, Procaine, Pontocaine, Xylocaine, Pronestyl and others.

The purpose of the discussion is to bring out both the use and abuse of various agents and show the advantages as well as the disadvantages of certain agents.

3:20—Recess.

3:30—Round Table Discussion.

EMERGENCY CALLS

Notify your office or exchange regarding the meetings you plan to attend. In cases of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, DUnkirk 7-7175; Sunday and evenings after 5:00 p.m., DUnkirk 7-8141.

DERMATOLOGY AND SYPHILOLOGY

Chairman.....Rees B. Rees, M.D., San Francisco
Secretary.....Frances Keddie, M.D., Palo Alto
Assistant Secretary.....Walter F. Schwartz, M.D., Pasadena

REES B. REES
Chairman

FRANCES KEDDIE
Secretary

TUESDAY, MAY 26

9:30—Auditorium, Sunkist Building

9:30—**Evaluation of Entozyme Treatment in Psoriasis**—Arne E. Ingels, M.D., San Francisco.

10:00—**Nutritional Aspects in Some Fungous Diseases** — Joseph D. Walters, M.D., Sherman Oaks.

10:30—**Interrelationships Between Dermatologist, Employee (Patient), Employer and Insurance Carrier**—A. Fletcher Hall, M.D., Santa Monica.

11:00—**Dermatopathology, Its Goal and Limitation** —Paul Fasal, M.D., San Rafael.

11:30—**Dermatoses of the Hands**—Clement E. Counter, M.D., Long Beach.

12:00—**Business Meeting and Election of Officers.**

TUESDAY, MAY 26

2:00—Auditorium, Sunkist Building

2:00—**Coccidioidomycosis as an Occupational Disease**—Norman E. Levan, M.D., Bakersfield.

2:30—**Chairman's Address — Anogenital Moniliasis** —Rees B. Rees, M.D., San Francisco.

3:00—**Primary Inoculation Cutaneous Coccidioidomycosis: a Clinical Rarity**—Charles E. Smith, M.D., Berkeley; J. Walter Wilson, M.D., Los Angeles, and Orda A. Plunket, Ph.D., Los Angeles, by invitation.

3:30—**The Use of Selenium Sulfide Ointment in the Treatment of Seborrheic Dermatitis of the Glabrous Skin and Other Dermatoses: A Preliminary Report** — Samuel Ayres III, M.D., and Samuel Ayres, Jr., M.D., Los Angeles.

3:40—**The Use of Silicones to Protect the Skin**— Grant Morrow, M.D., San Francisco

3:50—**The Use of Silicones in Dermatology**—Ralph T. Behling, M.D., San Mateo.

4:00—**The Treatment of Recalcitrant Vesiculopustular Eruptions of the Hands and Feet with a Sensitized Mixed Vaccine**—Edward A. Levin, M.D., and James H. Bennett, M.D., San Francisco.

4:10—**Treatment of Chronic Discoid Lupus Erythematosus with Quinacrine Hydrochloride**—B. L. Rhodes, M.D., San Francisco, by invitation, and M. F. Allende, M.D., San Francisco.

4:20—Discussion.

VISIT THE TECHNICAL AND SCIENTIFIC EXHIBITS

EYE, EAR, NOSE AND THROAT

Chairman . . . . . Robert C. McNaught, M.D., San Francisco
Secretary . . . . . Alfred R. Robbins, M.D., Los Angeles
Assistant Secretary . . . . . Francis A. Sooy, M.D., San Francisco

ROBERT C. McNAUGHT
Chairman

ALFRED R. ROBBINS
Secretary

TUESDAY, MAY 26

2:00—Conference Room 2, Biltmore Hotel

Symposium

Exophthalmos

2:00—**Exophthalmos from the Standpoint of the Endocrinologist**—Donald William Petit, M.D., Pasadena.

2:20—**Exophthalmos from the Standpoint of the Ophthalmologist**—A. Ray Irvine, Jr., M.D., Beverly Hills.

2:40—**Exophthalmos from the Standpoint of the Otolaryngologist**—Max Pohlman, M.D., Los Angeles.

3:00—**Exophthalmos from the Standpoint of the Neurological Surgeon**—Howard C. Naffziger, M.D., San Francisco.

3:20—**Questions and Round Table Discussion.**

Moderator: Robert C. McNaught, M.D., San Francisco.

Members of the Panel: Donald W. Petit, M.D., Pasadena; A. Ray Irvine, Jr., M.D., Beverly Hills; Max Pohlman, M.D., Los Angeles; and Howard C. Naffziger, M.D., San Francisco.

4:00—**Business Meeting and Election of Officers.**

PACIFIC COAST OTO-OPHTHALMOLOGICAL SOCIETY

Annual Meeting

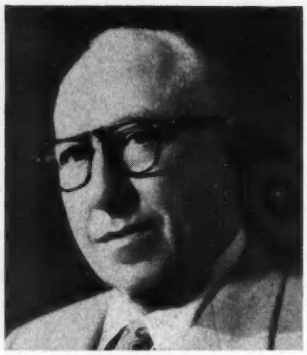
AMBASSADOR HOTEL, LOS ANGELES

Sunday, May 24 – Thursday, May 28

All clinical meetings are open to members of the California Medical Association

INDUSTRIAL MEDICINE AND SURGERY

Chairman.....Orris R. Myers, M.D., Eureka
Secretary.....Packard Thurber, Jr., M.D., Los Angeles
Assistant Secretary.....Dan Kilroy, M.D., Sacramento



ORRIS R. MYERS
Chairman

PACKARD THURBER, JR.
Secretary

MONDAY, MAY 25

9:30—Conference Room 2, Biltmore Hotel

9:30—**Surgical Treatment of Low Back Injuries**—Robert Bingham, M.D., Riverside.
Discussion.

10:00—**Experiences with Hip Prostheses**—Homer C. Pheasant, M.D., Los Angeles.
Discussion.

10:30—**The Primary Repair of Traumatic Digital Skeletal Losses by Phalangeal Recession**—Carl E. Nemethi, M.D., Los Angeles.
Discussion.

11:00—**The Postphlebitic Syndrome: Factors in Prognosis**—Roy J. Popkin, M.D., Los Angeles.
Discussion.

11:30—**Medical Evidence Before the Industrial Accident Commission**—Edmund D. Leonard, J.D., San Francisco, by invitation.
Discussion.

12:00—**Business Meeting and Election of Officers.**

TUESDAY, MAY 26

2:00—Auditorium, Southern California Edison Building
Joint Meeting with Section on General Practice

2:00—**Tendon Surgery in the Hand**—James N. Wilson, M.D., Los Angeles.
Discussion.

2:30—**The Early Surgical Treatment of Peripheral Nerve Injuries**—Eugene M. Webb, M.D., San Francisco.
Discussion.

3:00—**The Role of the Circulation in the Causation of Faulty Healing of Industrial Injuries of the Lower Extremities**—M. Laurence Montgomery, M.D., San Francisco.
Discussion.

3:30—**Present Status of Union Health and Welfare Plans in the San Francisco Bay Area**—Samuel R. Sherman, M.D., San Francisco.
Discussion.

4:00—**Chairman's Address: The Relation of the General Practitioner to Industrial Practice**—Orris R. Meyers, M.D., Eureka.
Discussion.

BRING PROPER IDENTIFICATION FOR REGISTRATION

OBSTETRICS AND GYNECOLOGY

Chairman.....Hervey K. Graham, M.D., San Diego
Vice-Chairman.....Donald W. de Carle, M.D., San Francisco
Secretary.....Harold K. Marshall, M.D., Glendale

HERVEY K. GRAHAM
Chairman

HAROLD K. MARSHALL
Secretary

THURSDAY, MAY 28

9:30—Conference Room 2, Biltmore Hotel

9:30—**External Version in Private Practice**—William R. Schumann, M.D., Los Angeles.

Discussion by A. M. McCausland, M.D., Los Angeles.

10:00—**Routine Manual Removal of Placenta**—Ralph L. Hoffman, M.D., San Diego.

Discussion by Philip A. Reynolds, M.D., Los Angeles, and Thomas E. Farthing, M.D., San Mateo.

10:30—**Review of 13,000 Consecutive Deliveries in a General Hospital Without a Death**—Stirling G. Pillsbury, M.D., Long Beach.

Discussion by Donald Dallas, M.D., San Francisco, and Donald G. Tollefson, M.D., Los Angeles.

11:00—**Management of the Pregnant Diabetic**—Ervin E. Nichols, M.D, San Marino.

Discussion by James Short, M.D., and Paula Horn, M.D., Los Angeles.

11:30—**Business Meeting and Election of Officers.**

THURSDAY, MAY 28

2:00—Conference Room 2, Biltmore Hotel

2:00—**Chairman's Address**—Hervey Graham, M.D., San Diego.

2:30—**Massive Obstetrical and Gynecological Hemorrhages**—Leroy E. Smale, M.D., and John Knauer, M.D., Bakersfield.

Discussion by Alex Glyn Davies, M.D., Los Angeles, and Ralph C. Benson, M.D., San Francisco.

3:00—**Four Years' Experience by Private Clinical Group with Papanicolaou Vaginal Smears**—Purvis L. Martin, M.D., San Diego.

Discussion by Herbert F. Traut, M.D., San Francisco.

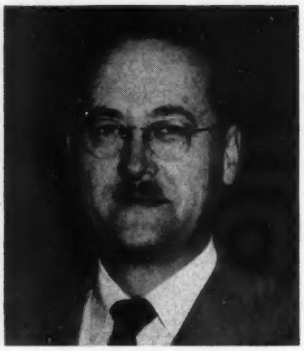
3:30—**Ureteral Injury During Vaginal Surgery**—Richard D. Pettit, M.D., Pasadena.

Discussion by Richard W. Jacobsen, M.D., Pasadena.

ADMISSION TO SESSIONS AND EXHIBITS BY REGISTRATION BADGE ONLY

PATHOLOGY AND BACTERIOLOGY

Chairman.....Charles M. Blumenfeld, M.D., Sacramento
Secretary.....A. R. Camero, Los Angeles
Assistant Secretary.....Paul Michael, Oakland



CHARLES M. BLUMENFELD
Chairman

A. R. CAMERO
Secretary

MONDAY, MAY 25

9:30—Conference Room 8, Biltmore Hotel

9:30—**Preservation of Acid Fast Bacilli**—Emil Bogen, M.D., Olive View, and Drake Will, Olive View, by invitation.

9:50—**Situs Inversus and Cardiovascular Malformation with Congenital Absence of Spleen**—Herbert Harder, M.D., by invitation, and A. F. Brown, M.D., Glendale.

10:10—**Metastatic Carcinoma of the Adrenal**—Weldon K. Bullock, M.D., San Gabriel, and Albert E. Hirst, Jr., M.D., Los Angeles.

10:30—**Gliomas and Diploic Dermoids of the Face**—Louisa E. Keasbey, M.D., Los Angeles.

11:00—**Primary Thrombocytopenic Purpura**—John R. Schencken, M.D., Omaha, Neb., by invitation.

12:30—Conference Room 1, Biltmore Hotel

12:30—Round Table Luncheon (by invitation only)—sponsored by the Section on Pathology and Bacteriology and the California Society of Pathologists.

MONDAY, MAY 25

2:00—Conference Room 8, Biltmore Hotel

2:00—**Acute Epiglottitis**—W. C. Thomas, M.D., Los Angeles, and F. A. Stone, M.D., Los Angeles, by invitation.

2:20—**Chairman's Address: Hyaline Membrane Disease of the Newborn**—Charles M. Blumenfeld, M.D., Sacramento.

3:00—**Rh Antibody Testing—The Choice of Technique**—Paul G. Hattersley, M.D., Sacramento.

3:20—**Business Meeting and Election of Officers.**

3:30—Adjourn to Renaissance Room, Clinical-Pathological Conference.

THURSDAY, MAY 28

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with Sections on Public Health, General Practice and Pediatrics.

Symposium on Encephalitis

For program, see Section on Public Health.

VISIT THE TECHNICAL AND SCIENTIFIC EXHIBITS

PEDIATRICS

Chairman.....Alvin H. Jacobs, M.D., San Francisco
Secretary.....Clement J. Molony, M.D., Beverly Hills
Assistant Secretary.....Gordon F. Williams, Menlo Park

ALVIN H. JACOBS
Chairman

CLEMENT J. MOLONY
Secretary

MONDAY, MAY 25

9:30—Auditorium, Sunkist Building

Joint Meeting with Section on Urology

For Program, see Section on Urology.

TUESDAY, MAY 26

9:30—Renaissance Room, Biltmore Hotel

9:30—**Problems in the Medical Management of Urinary Tract Infections**—Ernest Jawetz, M.D., San Francisco.

Discussion by William L. Hewitt, M.D., Los Angeles.

10:00—**Radioactive Iodine Treatment of Children with Hyperthyroidism**—Leon Oettinger, Jr., M.D., San Marino.

Discussion by Lorye E. Hackworth, M.D., Los Angeles.

10:30—**Developmental Diagnosis as an Aid in Detecting Delayed Development**—Russell Sands, M.D., Santa Monica.

Discussion by Arthur H. Parmelee, Sr., Beverly Hills.

11:00—**The Effect of Atomic Radiation in Pregnancy—A Study of Women Pregnant at the Time of the Atom Bomb Explosion in Nagasaki**—Stanley W. Wright, M.D., James M. Yamazaki, M.D., and Phyllis M. Wright, M.D., Los Angeles, all by invitation.

Discussion by Robert R. Newell, M.D., San Francisco.

11:45—**Business Meeting and Election of Officers.**

TUESDAY, MAY 26

2:00—Conference Room I, Biltmore Hotel

Panel Discussion

What's New in Pediatrics

2:00—**Maternal Rubella**—Carl A. Erickson, M.D., Pasadena.

2:20—**Radiation in ENT Practice**—Frank J. Novak, M.D., Menlo Park.

2:40—**Poliomyelitis Research**—John M. Adams, M.D., Los Angeles, by invitation.

3:00—**Strabismus Management**—Arthur Jampolsky, M.D., San Francisco.

3:20—**Electroencephalograms in Cerebral Palsy Cases**—Margaret Jones, M.D., Glendale.

3:40—**Practical Applications of Paper Electrophoresis**—Theodore H. Spaet, M.D., San Francisco.

4:00—**Pediatric Endocrinology**—Frank L. Plachte, M.D., Los Angeles.

4:20—**Western Equine Encephalomyelitis in Infancy**—Henry B. Bruyn, M.D., San Francisco, and Edwin H. Lennette, M.D., Berkeley.

THURSDAY, MAY 28

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with the Sections on Public Health, General Practice, Pathology and Bacteriology

Symposium on Encephalitis

For Program, see Section on Public Health.

PSYCHIATRY AND NEUROLOGY

Chairman.....Cyril B. Courville, M.D., Los Angeles
Secretary.....A. E. Bennett, M.D., Berkeley
Assistant Secretary.....Aidan A. Raney, M.D., Los Angeles

CYRIL B. COURVILLE
Chairman

A. E. BENNETT
Secretary

THURSDAY, MAY 28

9:30—Conference Room 1, Biltmore Hotel

9:30—**The Physician, the Parent, and the Retarded Child**—M. E. Porter, M.D., Eldridge, and Charles H. Ludwig, M.D., Porterville.

Discussion by Peter Cohen, M.D., San Francisco, and Arthur Parmelee, M.D., Los Angeles.

10:00—**The Symptom of Somnambulism** — Robert L. Jordan, Lt. MC, USNR; and Bernard I. Kahn, Cdr., MC, USN, Oakland, by invitation.

Discussion by Bernard I. Kahn, Cdr., MC, USN, Oakland.

10:30—**Comparison of Flaxedil and D-Tubocurarine for the Prevention of Complications in 1,000 Electric Shock Treatments**—L. G. McKeever, M.D., Oakland.

Discussion by A. E. Bennett, M.D., Berkeley, and Lester H. Margolis, M.D., San Francisco.

11:00—**A Practical Integrated Treatment Program for Mental Hospitals** — Frank F. Tallman, M.D., Sacramento.

Discussion by Douglas G. Campbell, M.D., San Francisco, and Norman Levy, M.D., Beverly Hills.

11:30—**Treatment of Migraine and Tensional Headaches**—Arnold P. Friedman, M.D., Naomi de Sola Pool, M.D., and Theodore J. C. von Storch, M.D., New York, N. Y., by invitation.

11:50—Discussion by Eugene Ziskind, M.D., and Johannes M. Nielsen, M.D., Los Angeles.

THURSDAY, MAY 28

2:00—Conference Room 1, Biltmore Hotel

2:00—**Chairman's Address: Anoxia and Brain Diseases**—Cyril B. Courville, M.D., Los Angeles.

2:30—**New Techniques of Physical Therapy for Relaxation of Spasticity—Milton G. Levine**, Ph.D., by invitation; Herman Kabat, M.D.; Margaret Knott, B.S., P.T., by invitation; and Dorothy E. Voss, B.Ed., R.P.T., by invitation, Vallejo.

Discussion by Tracy Jackson Putnam, M.D., Beverly Hills, and Fred B. Moor, M.D., Los Angeles.

3:00—**The Value of Electromyography in Neurology**—A. A. Marinacci, M.D., Los Angeles.

Discussion by Karl O. Von Hagen, M.D., Los Angeles.

3:30—**The Importance of Lumbar Sympathectomy in the Management of Certain Vascular and Visceral Disorders**—R. B. Raney, M.D., Los Angeles.

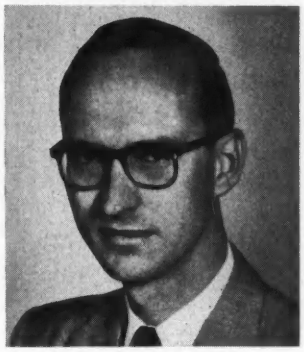
Discussion.

4:00—**Therapy of Cerebrovascular Disorders—An Evaluation of Present-day Methods of Treatment**—Edison D. Fisher, M.D., Los Angeles.

Discussion by Clarence W. Olsen, M.D., and Karl O. Von Hagen, M.D., Los Angeles.

PUBLIC HEALTH

Chairman . . . . . John R. Philp, M.D., San Francisco
Secretary . . . . . Charles E. Smith, M.D., Berkeley
Assistant Secretary . . . . . L. S. Goerke, M.D., Los Angeles



JOHN R. PHILP
Chairman

CHARLES E. SMITH
Secretary

THURSDAY, MAY 28

9:30—Auditorium, Sunkist Building

9:30—**Suicide and Public Health**—Herbert Bauer, M.D., Woodland.

Discussion.

9:55—**Cerebral Palsy—An Approach to the Problem**—Peter Cohen, M.D., San Francisco.

Discussion.

10:20—**The Public Health Implications of Recent Advances in Diagnosis and Management of Tuberculosis**—Reginald H. Smart, M.D., Los Angeles.

Discussion.

10:55—**Intermission.**

11:00—**Problems in Recruitment and Training of Public Health Personnel**—Ernest L. Stebbins, M.D., Baltimore, Md., by invitation.

Discussion.

11:30—**Chairman's Address**—John R. Philp, M.D., San Francisco.

11:40—**Business Meeting—Election of Officers.**

THURSDAY, MAY 28

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with Sections on General Practice, Pathology and Bacteriology, and Pediatrics

Symposium

Highlights of the 1952 Encephalitis Outbreak and Plans for the Future

2:00—**Problems in Differential Diagnosis of the Acute Disease**—Robert H. Kokernot, M.D., D.V.M., M.P.H., by invitation; Henry R. Shinefield, M.D., M.P.H., Sr. Asst. Surg. (R), U.S.P.H.S., by invitation; and W. Allen Longshore, Jr., M.D., M.P.H., Berkeley.

2:15—**Identification of Western Equine Encephalomyelitis by Laboratory Methods**—Edwin H. Lennette, M.D., Ph.D., Berkeley; and, by invitation, Marjorie C. Nyberg, A.B.; Dolores M. Barghausen, A.B.; Roland Chin, B.S.; Frances U. Fujimoto, A.B.; and Margaret K. Itatani, M.S., Berkeley.

2:30—**Some Epidemiological Aspects of the 1952 Outbreak**—Arthur C. Hollister, M.D., M.P.H.; and W. Allen Longshore, Jr., M.D., M.P.H., Berkeley; and, by invitation, Ben H. Dean, D.V.M., M.P.H.; and Ida May Stevens, M.A. (P.H.), Berkeley.

2:50—**Vector Control Measures of the 1952 Season and Their Implications for the Future**—Frank M. Stead, M.S.P.H.(E), San Francisco, and Richard F. Peters, B.S., Berkeley, both by invitation.

3:05—**Projected Long-Term Study of Patients From the Neurologic and Psychiatric Points of View**—Knox H. Finley, M.D., San Francisco; and W. Max Chapman, M.D., M.P.H., Berkeley.

3:20—**Discussion.**

3:40—**Status of Availability of Gamma Globulin for Prophylaxis of Poliomyelitis**—Wilton L. Halverson, M.D., Dr. P.H., San Francisco.

CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS

WEDNESDAY, MAY 27, and
FRIDAY, MAY 29

Auditorium, Sunkist Building
9:30 a.m. to 5:00 p.m.

RADIOLOGY

Chairman.....Robert K. Arbuckle, M.D., Oakland
Secretary.....Calvin L. Stewart, M.D., San Diego
Assistant Secretary.....H. R. Morris, M.D., Redlands

ROBERT K. ARBUCKLE
Chairman

CALVIN L. STEWART
Secretary

MONDAY, MAY 25

9:30—Conference Room 1, Biltmore Hotel

9:30—Aortography—A Discussion of Technique and Presentation of Pre- and Postoperative Cases in Abdominal Aortic Disease—A. Justin Williams, M.D., and Tom M. Fullenlove, M.D., San Francisco.

9:50—Indications for Angiocardiography — George Jacobson, M.D., Los Angeles, and John M. Clark, M.D., Los Angeles, by invitation.

10:10—Operative Cholangiography—John H. Gifford, M.D., and Samuel C. Kahlstrom, M.D., Los Angeles.

10:30—Problems of Myelography—Howard L. Jones, M.D., Palo Alto.

10:50—Roentgen Manifestations of Lymphosarcoma and Other Tumefactive Lesions of the Small Bowel—Paul H. Deeb, M.D., and Walter L. Stilson, M.D., Los Angeles.

11:10—Radiological Aspects of the Collagen Diseases—L. Henry Garland, M.D., and M. A. Sisson, M.D., San Francisco.

TUESDAY, MAY 26

9:30—Conference Room 1, Biltmore Hotel

9:30—High Voltage Radiography—Eldon D. Nickel, M.D., San Francisco, by invitation.

9:50—Physical Factors and Early Clinical Results of the 1000 Curie Cobalt^{60} Radiation Unit—W. E. Costolow, M.D.; Edward M. Cook, Jr., M.D., by invitation; and Roy W. Johnson, M.D., Los Angeles.

10:10—The Future of Therapeutic Radiology—Justin J. Stein, M.D., Los Angeles.

10:30—Recess — Business Meeting and Election of Officers.

10:40—Annual Meeting of Pacific Roentgen Society.

TUESDAY, MAY 26

2:00—Renaissance Room, Biltmore Hotel

Joint Meeting with the Sections on General Surgery and General Medicine

Symposium on Diseases of the Esophagus

For program, see Section on General Surgery.

ADMISSION TO SESSIONS AND EXHIBITS BY REGISTRATION BADGE ONLY

UROLOGY

Chairman.....Roger W. Barnes, M.D., Los Angeles
Secretary.....James A. May, M.D., San Diego
Assistant Secretary.....Thomas I. Buckley, M.D., Oakland

ROGER W. BARNES
Chairman

JAMES A. MAY
Secretary

MONDAY, MAY 25

9:30—Auditorium, Sunkist Building

Joint Meeting with Section on Pediatrics

9:30—**A Commentary on Ureteral Ectopia in Infancy and Childhood—Report of Eight Cases**—Frank R. Morrow, M.D., Hollywood.

Discussion opened by Charles M. Stewart, M.D., Los Angeles.

10:00—**Urinary Calculi Before Puberty**—Hans H. Zinsser, M.D., Los Angeles.

Discussion opened by Nathan G. Hale, M.D., Sacramento.

10:30—**Obstructive Genito-Urinary Lesions in Children**—Edgar Burns, M.D., New Orleans, La., by invitation.

Discussion opened by Carl Rusche, M.D., Hollywood.

11:00—**Abnormalities of the Scrotal Contents in Infancy and Childhood**—Donald A. Charnock, M.D., Los Angeles.

Discussion opened by Harold J. Kay, M.D., Oakland.

11:30—**Essential Nocturnal Enuresis Treated with Amphetamine Sulfate**—Samuel Roland, M.D., and Frank Hinman, Jr., M.D., San Francisco.

Discussion opened by Arthur H. Hurd, M.D., San Marino.

TUESDAY, MAY 26

9:30—Conference Room 4, Biltmore Hotel

9:30—**Unilateral Renal Diseases Associated with Hypertension**—Richard A. Peterfy, M.D., Los Angeles.

Discussion opened by Ector LeDuc, M.D., San Diego.

10:00—**The Clinical Entity of Hydronephrosis Secondary to Renal Ptosis, Torsion, Intrinsic and Extrinsic Ureteropelvic Obstruction**—Charles Pierre Mathe, M.D., San Francisco.

Discussion opened by Irving Wills, M.D., Santa Barbara.

10:30—**An Improved Method for the Extraction of Ureteral Stones**—B. M. Palmer, M.D., Oakland.

Discussion opened by Ben D. Massey, M.D., Pasadena.

11:00—**War Wounds of the Genito-Urinary Tract**—Robert M. Boughton, M.D., La Jolla, by invitation.

Discussion opened by Frederick C. Schlumberger, M.D., Beverly Hills.

11:30—**Present Day Concepts and Treatment of Genito-Urinary Tuberculosis**—Donald C. Malcolm, M.D., Long Beach.

Discussion opened by Ray C. Atkinson, M.D., Oakland.

TUESDAY, MAY 26

2:00—Conference Room 4, Biltmore Hotel

2:00—**Chairman's Address: Beyond the Surgeon's Skill**—Roger W. Barnes, M.D., Los Angeles.

2:30—**The Topical Use of Cortisone in Urology**—T. L. Schulte, M.D., San Francisco.

Discussion opened by Donald A. McCannel, M.D., Beverly Hills.

3:00—**The Diagnosis of Prostatic Carcinoma—A Comparison of Papanicolaou Stains, Needle**

Biopsy, Rectal Examination and Perineal and Transurethral Biopsies — Willard E. Goodwin, M.D.; Joseph J. Kaufman, M.D., by invitation; and Milton Rosenthal, M.D., Los Angeles.

Discussion opened by Bradford W. Young, M.D., San Francisco.

3:30—**Tumors of the Urinary Bladder—Present Day Method of Diagnosis and Treatment**—Gilbert J. Thomas, M.D., Santa Monica.

Discussion opened by Lyle G. Craig, M.D., Pasadena.

4:00—**Effect of Pudendal Nerve Operations on the Neurogenic Bladder**—Ernest Bors, M.D., by invitation; and A. Estin Comarr, M.D., Long Beach.

Discussion opened by Tracy O. Powell, M.D., Los Angeles.

4:30—Business Meeting and Election of Officers.

ADMISSION TO SESSIONS AND EXHIBITS BY REGISTRATION BADGE ONLY

BRING PROPER IDENTIFICATION FOR REGISTRATION

QUALIFICATIONS/REQUIREMENTS FOR REGISTRATION

(a) All M.D.'s with credentials showing that they hold valid license to practice medicine. (Membership card in C.M.A.; county medical society/association; or A.M.A. membership card.)

(b) Medical students will be admitted upon presentation of credentials from their medical schools identifying them as medical students. A membership card of the Student American Medical Association will be sufficient.

(c) Medical secretaries will be admitted upon presentation of a letter from the physician-employer.

(d) Pharmacist mates and other military personnel of a like grade will be admitted upon presentation of a letter requesting their admittance, written by their commanding officer.

(e) Dentists (D.D.S.), doctors of veterinary medicine (D.V.M.), registered nurses (R.N.), x-ray technicians, laboratory technicians, dietitians, allied public health personnel, and others will be admitted provided they have proper identification.

(f) *All questions on admission will be passed on by a member of the Committee on Registration who will be present at the desk.*

INDEX TO SPEAKERS

Los Angeles, May 24-May 28, 1953

Scientific Exhibits

Main Galeria and North Galeria, Biltmore Hotel

• *Main Galeria*

Studies of One Thousand Patients with Vascular Headaches—Arnold P. Friedman, M.D., and Theodore J. C. von Storch, M.D., New York, N. Y., both by invitation.

Electronarcosis—Esther Bogen Tietz, M.D.; and Joaquim A. Haenel, M.D., Los Angeles; Gordon A. Dayton, M.D., Arcadia; and Robert E. Litman, M.D., Beverly Hills.

Mechanisms in Conception and Infertility—Edward T. Tyler, M.D., Los Angeles.

Wire Sutures and Ligatures: Points in Technique—James I. Knott, M.D., San Diego.

The Mechanism of Nerve Root Compression by the Posterior Elements in Spondylolisthesis and in Spina Bifida Occulta of the First Sacral Segment—Gerald G. Gill, M.D., and Hugh L. White, M.D., San Francisco; and John G. Manning, M.D., Pasadena.

• *North Galeria*

Carcinoma of the Lung in X-Ray Surveys—Alfred Goldman, M.D., Beverly Hills; Marvin S. Harris, M.D., Los Angeles, and I. Alfred Breckler, M.D., Beverly Hills.

Modern Antigen Therapy in Chronic Disease—John B. McDonald, M.D.; William H. Davis, M.D., by invitation; Henry K. Oetting, M.D., and Kyle E. Townsend, M.D., Hollywood.

New Techniques for Proctoscopy and Minor Rectal Surgery—Paul C. Blaisdell, M.D., Pasadena.

Aortography and Retroperitoneal Pneumography—W. E. Goodwin, M.D., and R. C. Walter, M.D., and J. J. Kaufman, M.D., Los Angeles; John Getz, M.D., Torrance, by invitation; and Arthur J. Bischoff, M.D., Los Angeles, by invitation.

Organizational Exhibits

Main Galeria, Biltmore Hotel

C.M.A. Public Relations

C.M.A. Blood Bank Commission

C.M.A. Cancer Commission, American Cancer Society, U. S. Food and Drug Administration, State Department of Public Health

C.M.A. Committee on Postgraduate Activities

Los Angeles County Physicians Aid Association

The Student Nurse Recruitment Committee of California

Motion Picture Program

Arthur E. Smith, M.D., D.D.S., Los Angeles, Chairman

Medical Motion Pictures Committee

SURGICAL FILM EXHIBITION

MONDAY, MAY 25

9:00 a.m. to 5:30 p.m., Biltmore Hotel

Galeria Room

9:00—**The Physiologic Basis for the Action of ACTH in Human Beings**—The Armour Laboratories.

9:42—**Carcinoma of the Thyroid**—R. Lee Clark, Jr., M.D., Houston.

10:12—**Early Care of Plastic Surgical Cases — Wounds of the Face and Jaw**—Navy Department.

10:32—**Electroencephalogram**—A. E. Bennett, M.D., and P. T. Cash, M.D., Berkeley.

10:47—**The Mechanism of Nerve Root Compression in Spondylolisthesis as Revealed at Surgery**—Gerald G. Gill, M.D., Hugh L. White, M.D., San Francisco, and John G. Manning, M.D., Pasadena.

11:05—**Total Abdominal Hysterectomy and Bilateral Salpingo-Oophorectomy**—Douglas Donath, M.D., Pasadena.

11:20—**Some Aspects of Accessible Cancers—Skin**—American Medical Association.

11:49—**Fractures: An Introduction**—American College of Surgeons Committee on Fractures and other Traumas.

12:34—**Excision Anal Fissure, Fistulectomy and Hemorrhoidectomy with Caudal Anesthesia**—Neil Swinton, M.D., and Urban Eversole, M.D., Boston.

1:04—**Anterior Resection of Rectosigmoid with Primary Anastomosis** — G. V. Brindley, M.D., Temple, Texas.

1:34—**Keratoplasty**—Ramon Castroviejo, M.D., New York City.

1:50—**Excision of Hyperfunctioning Islet Cell Tumor of Pancreas** — Conrad J. Baumgartner, M.D., Beverly Hills.

2:08—**Complete Exenteration of the Pelvis**—Alexander Brunschwig, M.D., and Virginia K. Pierce, M.D., New York City.

2:45—**Transverse Incision for Esophageal Pulsion Diverticulum of the Esophagus**—Samuel Perzik, M.D., Beverly Hills.

3:02—**Vagus Resection—Transthoracic Approach**—Edward C. Pallette, M.D., Los Angeles.

3:17—**Surgery of Abdominal Cryptorchidism (Torek Operation)**— Harry A. Zide, M.D., Lester A. Riskind, M.D., Beverly Hills, and A. A. Kutzmann, M.D., Los Angeles.

3:42—**A Case of True Hermaphrodism**—Elmer Hess, M.D., and Associates, Erie, Pa.

4:10—**Wiring of the Thoracic Aortic Aneurysm**—J. Norman O'Neill, M.D., Los Angeles.

4:20—**Plastic Reconstruction of Cleft Palate and Associated Deformities** — Arthur E. Smith, M.D., D.D.S., Los Angeles.

4:45—**Surgical Treatment of Varicose Veins**—Henry N. Harkins, M.D., Seattle.

5:15—**Correction of Cleft Lip**—T. J. Blocker, Jr., M.D., Galveston.

TUESDAY, MAY 26

9:00 a.m. to 5:30 p.m., Biltmore Hotel

Galeria Room

9:00—**Vertigo—Differential Diagnosis**—Myron M. Hipskind, M.D., and Samuel Salinger, M.D., Chicago.

9:30—**The Antibiotics and Terramycin** — Alan Wright, M.D., New York, N. Y.

9:50—**Abdominoperineal Resection for Carcinoma of the Rectum** — Richard B. Cattell, M.D., Boston.

10:05—**One-Stage Right Hemicolectomy** — William M. McMillan, M.D., Chicago.

10:36—**Repair of Ruptured Peptic Ulcer**—Philip Thorek, M.D., Chicago.

10:52—**Prefrontal Lobotomy in Chronic Schizophrenia**—A. E. Bennett, M.D., Berkeley.

11:13—**The Technique of Aortography and Retroperitoneal Pneumography**—Willard E. Goodwin, M.D., UCLA School of Medicine.

11:33—**Hand Surgery—Secondary Repair of Severed Motor Branches of the Median and Ulnar Nerves. Resection of the Scar** — Joseph Parker, M.D., Los Angeles.

11:50—**Familial Periodic Paralysis**—Harold N. Perelson, M.D., Los Angeles.

12:05—**Reconstruction Surgery Following Poliomyelitis** — Daniel H. Levinthal, M.D., Beverly Hills.

12:35—**Treatment of Cysts**—Harry M. Seldin, D.D.S., S. Daniel Seldin, D.D.S., and William Rakower, D.D.S., New York City.

1:05—**Surgical Treatment of Prognathous or Protruding Mandibles** — George F. Seeman, D.D.S., Nashville.

1:35—**Polyps of the Large Intestines**—Hilger Perry Jenkins, M.D., Chicago.

1:59—**Operative Technique in Surgery of the Hand**—Joseph H. Boyes, M.D., Los Angeles.

2:19—**Radical Neck Dissection**—Frank H. Lahey, M.D., Boston.

2:37—**Abdominal Complete Hysterectomy**—William F. Mengert, M.D., Dallas, Texas.

2:57—**Radical Groin Dissection for Malignant Melanoma**—Jack M. Farris, M.D., Los Angeles.

3:15—**Congenital Absence of Vagina** — Virgil S. Counsellor, M.D., Rochester, Minn.

3:32—**A New Method of Lining the Artificially Constructed Vagina with Skin Grafts** — E. Eric Larson, M.D., and Arthur E. Smith, M.D., D.D.S., Los Angeles.

3:47—**Exposure Treatment of Burns in Children**—William S. Kiskadden, M.D., and Sanford R. Dietrich, M.D., Los Angeles.

4:07—**The Mechanism of Nerve Root Compression in Spina Bifida Occulta of the First Sacral Segment as Revealed at Surgery**—Gerald G. Gill, M.D., Hugh L. White, M.D., San Francisco, and John G. Manning, M.D., Pasadena.

4:25—**A New Surgical Approach for the Correction of Congenital Retrusion of the Mandible; Congenital Undeveloped Symphysis: Acquired Deformity of Palate with Marked Protrusion of the Upper Alveolar Arch and Teeth**—Marsh Robinson, M.D., D.D.S., Los Angeles.

4:55—**The Surgical Repair of the Voluminous Ventral Hernia** — M. George Henry, M.D., Los Angeles.

5:25—**Subtotal Colectomy and Ileostomy for Ulcerative Colitis**—George Crile, Jr., M.D., Cleveland.

WEDNESDAY, MAY 27

9:00 a.m. to 5:30 p.m., Biltmore Hotel

Galeria Room

9:00—**Repair of Bladder Hernia**—Alfred H. Iason, M.D., Brooklyn.

9:15—**Supraomohyoid Neck** — Grantley W. Taylor, M.D., Boston.

9:25—**Open Reduction of Tibia and Fibula for Malunion**—Edwin F. Cave, M.D., and Carter R. Rowe, M.D., Boston.

9:49—**Skin Grafting**—H. O. McPheeters, M.D., Minneapolis.

10:22—**Neurosurgery: Facial Neuralgia**—Navy Department.

10:33—**The Technique of Femoral Thromboendarterectomy**—Wiley F. Barker, M.D., Veterans Hospital, Los Angeles.

10:49—**Technique for Reconstruction of Budding Herniated Indonesian Type of Breast**—Harold I. Harris, M.D., Los Angeles.

11:06—**Differential Diagnosis of Lesions of the Cervix**—A. M. Hansen, M.D., Los Angeles.

11:31—**Repair of Mandibular Defects of Jaw**—Henry S. Patton, M.D., Oakland.

12:01—**Colotomy for Polyp**—William H. Daniel, M.D., and George C. Tyler, M.D., Los Angeles.

12:16—**Simple Vaginal Hysterectomy, Heaney Technique**—Edward D. Allen, M.D., and L. Peterson, M.D., Chicago.

12:44—**Surgical Preparation of the Mouth for Immediate Dentures** — Ralston I. Lewis, M.D., D.D.S., Chicago.

1:02—**Surgical Correction of Unilateral Prognathism**—Leonard Z. Lyon, D.D.S., Los Angeles.

1:27—**Hypertension Due to Pheochromocytoma** — Reginald H. Smithwick, M.D., Boston.

1:40—**Total Pneumonectomy for Carcinoma of the Right Upper Lobe**—Lyman Brewer III, M.D., Los Angeles.

2:03—**Augmentation Mammaplasty by Lipo Transplant**—H. O. Bames, M.D., Los Angeles.

2:18—**Subtotal Colectomy and Ileostomy for Ulcerative Colitis**—George Crile, Jr., M.D., Cleveland.

2:34—**Radical Operation for Cancer of the Cervix**—Joe Vincent Meigs, M.D., Boston.

3:05—**Surgical Anatomy of the Parotid Gland**—Conrad J. Baumgartner, M.D., Beverly Hills.

3:25—**Recent Modifications of Convulsive Shock Therapy** — A. E. Bennett, M.D., and P. T. Cash, M.D., Berkeley.

3:45—**Oral Surgical Procedures**—Samuel A. Brandon, D.D.S., Portland.

4:30—**Adult Tonsillectomies Using Sodium Pentothal, Curare, Pontocaine and Novocain as the Anesthetic**—Fordyce Johnson, M.D., Pasadena.

4:50—**Radical Neck Dissection for Carcinoma of the Mouth**—Samuel Kaplan, M.D., Beverly Hills.

5:02—**The Repair of the Unilateral Cleft Lip by the Stencil Method**—Charles W. Tennison, M.D., San Antonio.

5:12—**Reconstruction Nasal Half Upper Lid**—Wendell L. Hughes, M.D., Hempstead, N. Y.

WEDNESDAY EVENING, MAY 27

7:00 p.m. to 11:00 p.m., Biltmore Hotel

Galeria Room

7:00—**Sciatic Pain and the Intervertebral Disc** — American Medical Association.

7:26—**Resection of the Right Colon for Carcinoma**—Arthur W. Allen, M.D., Boston.

7:39—**Delivery of Quadruplets** — John C. Ullery, M.D., Philadelphia.

8:08—**Transtrochanteric Osteotomy of the Femur for Non-Union of the Neck**—Stanley Haft, M.D., Los Angeles.

8:23—**Thoracolumbar Sympathectomy with Rib Resection**—J. Norman O'Neill, M.D., Los Angeles.

8:40—**Surgical Treatment of Pituitary Tumors**—C. Hunter Shelden, M.D., Pasadena.

9:00—**Fascia Latal Transplant Repair of Inguinal Hernia**—Louis C. Bennett, M.D., Los Angeles.

9:15—**New Operation for Equinous Deformity: Osteotomy and Bone Graft to Os Calcis**—Hugh Toland Jones, M.D., and Arthur E. Smith, M.D., D.D.S., Los Angeles.

9:30—**Total Hysterectomy**—William H. Brownfield, M.D., Los Angeles.

9:45—**The Story of Lucy**—Henry H. Kessler, M.D., Newark.

10:03—**Treatment of Burns and Cutaneous Abrasions** —M. Gonzalez Ulloa, M.D., Mexico City.

10:33—**Special Problems in the Management of Peptic Ulcer**—Wyeth Laboratories.

THURSDAY, MAY 28

9:00 a.m. to 4:00 p.m., Biltmore Hotel

Galeria Room

9:00—**Correction of Facial Paralysis by Means of Muscle Transplant: Comparison with Results Using Fascia Transplant**—Neal Owens, M.D., New Orleans.

9:40—**Oral Cancer: The Problem of Early Diagnosis** —American Cancer Society.

10:00—**Plastic Reconstruction of the Burned Patient** —Arthur E. Smith, M.D., D.D.S., Los Angeles.

10:45—**Resistive Exercise Techniques Employed in the Treatment of Respirator Poliomyelitis Patients** — O. Leonard Huddleston, M.D., Santa Monica.

11:15—**Diagnosis of Poliomyelitis**—National Foundation for Infantile Paralysis.

11:35—**Having a Baby**—J. Harold Cantarow, M.D., Beverly Hills.

11:50—**Repair of Postoperative Ventral Hernia with Surgaloy Stainless Steel Mesh**—Kenneth C. Sawyer, M.D., and F. R. Spencer, M.D., Denver.

12:07—**Repair of Vesicovaginal Fistula**—Roger W. Barnes, M.D., Los Angeles.

12:22—**The Surgical Preparation of the Mouth for Dentures**—V. H. Kazanjian, M.D., Boston.

12:37—**Hand Reconstruction**—William H. Frackelton, M.D., Milwaukee.

12:54—**Surgical Repair of Complete Uterine Prolapse** Edward Allen, M.D., Chicago.

1:19—**Subtotal Gastrectomy**—Joel W. Baker, M.D., Seattle.

1:44—**Pulmonary Valvulotomy** — John C. Jones, M.D., Los Angeles.

2:05—**Reconstruction of the Lower End of the Femur with Use of Acrylic Prosthesis**—George Kraft, M.D., and Daniel H. Levinthal, M.D., Beverly Hills.

2:20—**Primary Hyperparathyroidism Due to Parathyroid Adenoma: Diagnosis and Surgical Treatment**—Joel W. Baker, M.D., and Randolph P. Pillow, M.D., Seattle.

2:46—**The Pterygopalatine Injection for Blocking the Maxillary Nerve** — Joseph Grodjesk, D.D.S., and Leonard Szerlip, D.D.S., Jersey City.

3:11—**Splenectomy in the Treatment of Hypersplenism**—Robert M. Zollinger, M.D., and E. H. Ellison, M.D., Columbus, Ohio.

3:44—**General Anesthesia in Oral Surgery**—George L. Robinson, M.D., and D. E. Walters, D.D.S., Waterloo, Iowa.

WOMAN'S AUXILIARY

to the

CALIFORNIA MEDICAL ASSOCIATION

Twenty-Third Annual Convention, May 24 to 26, 1953

Headquarters: Biltmore Hotel, Los Angeles

MRS. RALEIGH W. BURLINGAME
President

MRS. CARL BURKLAND
President-elect

Convention Chairman: MRS. J. JAMES DUFFY

REGISTRATION

Sunday, May 24—9 a.m. to 4:00 p.m.

Monday, May 25—8:30 a.m. to 4:00 p.m.

Tuesday, May 26—8:30 a.m. to 12 noon.

SUNDAY, MAY 24

8:00 a.m.—Executive Committee meeting, President's Suite, Biltmore Hotel.

10:00 a.m.—Pre-Convention Board meeting, Conference Room 8, Biltmore Hotel.

MONDAY, MAY 25

9:30 a.m.—First General Session of the Twenty-third Annual Convention, Alexandria Hotel, 210 West Fifth Street. Mrs. Raleigh W. Burlingame, President, presiding.

1:30 p.m.—Opening Session of the California Medical Association. Report of the year's work of the Woman's Auxiliary by the President, Mrs. Raleigh W. Burlingame. All Auxiliary members and doctors' wives are invited to attend. Renaissance Room, Biltmore Hotel.

4:00-6:00 p.m.—Reception, honoring Mrs. Lewis A. Alesen, wife of the President of the California Medical Association. All doctors' wives and their husbands are invited. Rendezvous Room, Biltmore Hotel.

7:30 p.m. — California Medical Association dinner and dance, honoring the President, Dr. Lewis A. Alesen. Biltmore Bowl, Biltmore Hotel. Formal dress optional.

TUESDAY, MAY 26

9:00 a.m.—Second General Session of the Twenty-third Annual Convention, Ballroom, Alexandria Hotel. Mrs. Raleigh W. Burlingame, president, presiding.

1:00 p.m.—Luncheon, honoring Mrs. Raleigh W. Burlingame, Mrs. Carl Burkland, the State Advisory Board and past state presidents. Embassy Room, Ambassador Hotel, 3400 Wilshire Boulevard.

3:00 p.m.—Post-Convention Board meeting. Rose Room, Ambassador Hotel, Mrs. Carl Burkland presiding.

ENTERTAINMENT

There will be tickets available for live TV and radio broadcasts for members and guests. A trip to the Huntington Library or a garden tour is also interesting. Inquire at table marked *Entertainment*.

Technical Exhibits

The technical exhibitors will be housed this year in the Ballroom, the Ballroom Foyer and the Music Room. There will be 95 exhibitors, displaying the newest products and services for the benefit of those attending the meeting.

Exhibits have been arranged to allow a maximum of space for circulation and for visiting with the exhibitors.

All physicians and their registered assistants are welcome in the exhibit areas and it is hoped that all will take advantage of this opportunity to refresh themselves on everything that is new and good in the science and art of medical practice. Only at annual meetings is such a display available.

Under the five-day meeting schedule in use this year for the first time, ample time will be available for visiting the exhibits. Please take this time to visit with the exhibitors, to learn about new items for yourself and to show your exhibitors that you appreciate their substantial contribution to your annual session.

A list of exhibitors and their displays is given below.

Room and Booth No.

ABBOTT LABORATORIES — **Ballroom Foyer—12**
North Chicago, Illinois

Abbott will present an animated exhibit on DESOXYN Hydrochloride (Methamphetamine-Hydrochloride, Abbott) showing the use of the product in the management of certain cases of obesity. In the cast of characters are a green snake, Temptation, and a wavering dieter. DESOXYN, in addition to curbing the appetite, imparts a feeling of well-being and increases mental and physical activity. DESOXYN also is indicated as an adjunct in convalescence and prolonged illness. Because DESOXYN is more potent than other sympathomimetic amines, smaller dosages produce the desired central effect—and with a minimum of side effects.

AMES COMPANY, Inc. — **Ballroom—29**
Elkhart, Indiana

APAMIDE—prescription analgesic—antipyretic (N-acetyl-p-aminophenol) of rapid and prolonged action.

APROMAL—non-narcotic, non-barbiturate sedative (acetylcarbromal) plus N-acetyl-p-aminophenol.

DECHOLIN SODIUM is foremost in combating serum-sickness penicillin reactions. Dramatic patient-relief has been noted within a few hours after intravenous DECHOLIN SODIUM, followed by adequate oral DECHOLIN.

AYERST, McKENNA & HARRISON, Ltd. — **Ballroom—46**
New York, New York

You are cordially invited to visit Booth 46 to relax and discuss the Ayerst line of prescription specialties with our representatives. Literature and information relative to "Premarin" may be had at the booth. Representatives will be glad to discuss new developments with you, answer any questions, or have you just visit. Here is an opportunity to become better acquainted with us.

BABY DEVELOPMENT CLINIC — **Ballroom—41**
Chicago, Illinois

To aid maternity patients demonstration samples and literature concerning carefully selected supportive brassieres and sashes. Manual: simple, direct, cheerful, authoritative—helps parents prepare for coming baby. Film strips, slides and outlines for parents' classes.

THE BAKER LABORATORIES, Inc. — **Ballroom Foyer—14**
Cleveland, Ohio

Baker's Modified Milk (Carbohydrate added) and Varamel (no Carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by the replacement of the milk fat with animal and vegetable oils and by the addition of vitamins and iron.

BARNES-HIND LABORATORIES, Inc. — **Ballroom—25**
San Francisco

Barnes-Hind Laboratories, Inc., is pleased to present our new product TRANQUINAL, which is a combination of Scopolamine-Aminoxide Hydrobromide (detoxified Scopolamine) and two open chain ureides. This combination is indicated wherever sedation is desired and has the advantage of no side or after effects. This drug also has the advantage of rapid absorption and detoxification and may be used with complete safety.

TAKON will also be presented. This is a new waterproofing agent which gives complete protection and is non-irritating.

May we have the pleasure of seeing you at our Booth 25.

DON BAXTER, Inc. — **Ballroom Foyer—6**
Glendale

Well informed Baxter representatives will be available to discuss several of the newest developments in parenteral and tubal nutrition. Featured at the Baxter exhibit will be Calorigen 1000, the first heat-sterilized nutrient solution commercially available for nasogastric tubal feeding; Isolyte (Balanced Electrolyte Solutions) with and without dextrose; Hyprotigen with 0.15% Potassium Chloride; Dextrathyl, 5% alcohol and 25% dextrose; and Kaladex, 0.2% Potassium Chloride in 5% dextrose. You'll also see the remarkable new Pharmaseal 8-French plastic feeding tube, for greater patient comfort.

Room and Booth No.

BECTON, DICKINSON & CO. — **Music Room—75**

Rutherford, New Jersey

Becton, Dickinson and Company, Rutherford, New Jersey, cordially invite you to visit their booth and discuss with the representatives the advantages of the new Men's and Women's full-footed, nylon elastic hosiery. Also on display will be our general line of Hypodermic Syringes, Needles, Clinical Thermometers, Ace and Asepto Bandages.

BEECH-NUT PACKING COMPANY — **Music Room—96**

Canajoharie, New York

The Beech-Nut Packing Company invites you to visit their booth. The Nutrition Staff will be on hand to answer any questions you may have regarding the use, ingredients and value of the STRAINED AND JUNIOR BABY FOODS.

ERNST BISCHOFF COMPANY — **Ballroom—28**

Ivoryton, Connecticut

Ernst Bischoff Company will exhibit for the first time at this California Medical Association convention. They will feature Aminet Suppositories, Anayodin, Diatussin, Bi-Co-Tussin, and My-B-Den. Information and reprints on these products will be available at the booth.

THE BORDEN FOOD PRODUCTS COMPANY

San Francisco — **Ballroom—27**

You are cordially invited to our booth for a refreshing cup of Borden's pure coffee with that good old-fashion flavor. Borden's famous Elsie and the lively baby doll will be there to encourage your smiles. Trained personnel will be available to answer questions and supply you with helpful printed material.

BOYLE & COMPANY — **Music Room—78**

Los Angeles

Boyle & Company will feature Boyle Pre-Natals, Boyle Hematinics, Opidice, Deimal, Friva and other products Council Accepted.

A. M. BROOKS COMPANY — **Music Room—72**

Los Angeles

We shall once again be happy to have you visit us at Booth 72, where we shall exhibit the following electro-medical equipment: the most up-to-date and outstanding diathermy in the nation, the Raytheon MICROTHERM, microwave diathermy. Also exhibiting the Edin, ink-writing Electrocardiograph—Ballistodyne, Ballistocardiograph —AMBCO Hearing Amplifier—Metabasal units, (portable) Ultraviolet and Infrared lamps—vibrators, and other accessories.

BURROUGHS WELLCOME & CO., Inc. — **Music Room—88**

Tuckahoe, New York

'AEROSPORIN'® OTIC SOLUTION STERILE—has a wide antibacterial action, and is especially effective against *Ps. aeruginosa*. It consists of 'Aerosporin'® Sulfate Polymyxin B Sulfate in acidified propylene glycol. It is hygroscopic, and has a low surface tension.

Room and Booth No.

'POLYSPORIN'® POLYMYXIN B—BACITRACIN OINTMENT—has a broad antibacterial action. Used for treating pyogenic conditions of the eye and skin, and infected lesions. Also for preventing infections in clean wounds and burns.

BUSINESS AND MEDICAL REGISTRY — **Ballroom—50**

Los Angeles

Business and Medical Registry through long association with the medical profession in California and other western states is qualified to discuss affiliations for the physician and also to submit data on available candidates for consideration where appointments are to be made. A welcome awaits in Booth 50.

CAMEL CIGARETTES — **Music Room—64, 65**

New York, New York

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

S. H. CAMP AND COMPANY — **Ballroom—31**

Jackson, Michigan

S. H. Camp and Company, Booth 31, cordially invites you to visit their exhibit to see the Plastica Orthopraxic Appliances of tomorrow. The Plastica Cervical, Taylor and Goldthwaite braces are integrally formed of plastic. Functionally correct anatomical designs insure improved wearing qualities, rigid support and they are completely washable and all at less cost to the patient than conventional steel braces. Representatives in attendance will be glad to answer questions about Plastica braces and other Camp Supports.

ELDON H. CANRIGHT COMPANY, Inc. — **Music Room—81**

Glendale

You are cordially invited to visit our booth where courteous and well informed personnel will be available to discuss our products.

CARNATION COMPANY — **Ballroom—49**

Los Angeles

You are cordially invited to visit the Carnation Company Booth 49 where you will see an attractive Trans-Illumination of the Carnation Experimental Farm near Seattle, Washington. The various uses of Carnation Evaporated Milk for infant feeding, child feeding and general diet purposes will be explained. Valuable and interesting literature will be available for you.

WARNER CHILCOTT LABORATORIES — **Music Room—70**

New York, New York

Two new cardiovascular agents will be featured at the Warner Chilcott booth. Medical representatives and research personnel will welcome an opportunity to discuss Methium, an effective oral hypotensive, and Peritrate, a vasodilator for prophylaxis in angina pectoris.

Gelusil, long known for acid control in peptic ulcer without constipation, will also be on display.

Room and Booth No.

CIBA PHARMACEUTICAL PRODUCTS, Inc.

Summit, New Jersey — **Ballroom Foyer—2**

Ciba's exhibit (Booth 2) features two new agents for more effective management of hypertensive disorders—REGITINE, for simple and accurate diagnosis of hypertension produced by pheochromocytoma — APRESOLINE, an agent of choice for gradual sustained lowering of blood pressure.

You are invited to visit the Ciba booth for literature on APRESOLINE and REGITINE.

THE COCA-COLA COMPANY — **Music Room—69**

Atlanta, Georgia

Ice cold Coca-Cola served through the cooperation and courtesy of the Coca-Cola Bottling Company of Los Angeles and The Coca-Cola Company.

CONTINENTAL MEDICAL BUREAU — **Ballroom—26**

Los Angeles

Continental Medical Bureau, Agency, Los Angeles, will have representatives in Booth 26. This is the oldest medical bureau in the state and their many contacts assure you of prompt service if you wish a physician-surgeon in your offices, a specialist for a group or if you wish to relocate. Locations and areas checked for suitability. All services confidential. Drop by and say hello at Booth 26.

CUTTER LABORATORIES — **Ballroom Foyer—3**

Berkeley

Cutter Laboratories, Booth 3, will display "Alhydrox" adsorbed toxoids and combined vaccines, as well as the Human Blood Fractions — Hypertussis, Immune Serum Globulin and the exclusive Albumin Shock Kit.

Also on exhibit will be the complete Cutter Saftiflask Solutions line, featuring the Saftitab Stopper—safer because it's solid, yet with open stopper convenience. The new built-in Safticlamp on IV, blood and plasma infusion equipment will be demonstrated. At no extra cost this revolutionary new clamp provides precision control of fluid with just one hand. The Safticlamp is on all Cutter, all-plastic, expendable sets which are designed for safe pressure administration.

F. A. DAVIS COMPANY — **Music Room—90**

Philadelphia, Pennsylvania

The new Loose Leaf Cyclopedia of Medicine, Surgery and Specialties was just completed last year. See this outstanding work and the first annual revision now in preparation. Many textbooks are also on display including Judovich & Bates, *Pain Syndromes;* Murphy, *Medical Emergencies;* Stroud, *Cardiovascular Disease;* Lederer, *Diseases of the Ear, Nose and Throat;* Pillmore, *Clinical Radiology.*

DESITIN CHEMICAL COMPANY — **Music Room—61**

Providence, Rhode Island

DESITIN Ointment: The pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

DESITIN Powder: a unique, dainty medicinal powder saturated with cod liver oil.

Room and Booth No.

DESITIN Hemorrhoidal Suppositories with Cod Liver Oil: coats anorectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

DESITIN Lotion: the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in nonspecific dermatitis, pruritus, poison ivy, etc.

DEVEREUX SCHOOLS — **Music Room—84**

Santa Barbara

Large color photos of the school campus and leather, ceramic and jewelry items made by the children are featured in the Devereux Schools exhibit.

The Devereux Foundation offers "tailor made" education for children who are unable to adjust themselves in the public schools—either because of emotional, academic or intellectual problems.

In a boarding school setting, the Devereux Schools offer the finest educational and clinical facilities plus an outstanding staff of specialists to assist physicians to meet the needs of their school age patients who are failing in their home communities.

THE DIETENE COMPANY — **Ballroom—48**

Minneapolis, Minnesota

Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.

MERITENE, the economical and palatable whole protein supplement, and DIETENE, the "Council Accepted" reducing supplement, will be on display.

DOHO CHEMICAL CORPORATION — **Music Room—94**

New York, New York

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (Gram negative-Gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring RECTALGAN, the liquid topical anesthesia, also Bactericidal and Fungicidal for control of secondary invaders, particularly recommended for treatment of mold infections (monilia) occurring after antibiotic therapy; also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

ENCYCLOPAEDIA BRITANNICA, Inc. — **Music Room—86**

Chicago, Illinois

For promotion of Encyclopaedia Britannica Publications.

ENDO PRODUCTS, Inc. — **Music Room—77**

Richmond Hill, New York

Endo Products takes this occasion to welcome its many friends to our exhibit, where we will feature several of our many Council-Accepted products. We will have trained personnel on hand to discuss CUMERTILIN TABLETS and INJECTABLE, the new oral and injectable mercurial diuretics, as well as many of our other products which have been favorably received by the medical profession.

Room and Booth No.

C. B. FLEET COMPANY, Inc. — **Ballroom Foyer—14**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to stop at Booth 14 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 gm. and sodium phosphate 18 gm.

Phospho-Soda (Fleet) over the years has won discriminating preference of physicians because of its controlled action . . . its freedom from undesirable side effect—and its ease of administration.

There is only ONE Phospho-Soda (Fleet).

GEIGY PHARMACEUTICALS — **Music Room—83**
New York, New York

The Geigy exhibit will feature BUTAZOLIDIN, the totally new, orally effective compound with an exceptionally broad field of usefulness in arthritis and allied disorders. Clinically, BUTAZOLIDIN (brand of phenylbutazone) brings quick relief and often functional improvement to the majority of patients with rheumatoid arthritis, osteo-arthritis, spondylitis, gout, arthritis with psoriasis, peritendinitis, fibrositis, and other painful musculoskeletal disorders. Ask for the brochure "Essential Clinical Data on BUTAZOLIDIN," and other literature which will be made available. Also on display will be Council-Accepted TROMEXAN, a new, safer, faster-acting, less cumulative, oral anticoagulant; EURAX Cream, a new, long-acting, nonsensitizing, antipruritic and scabicide; and PANPARNIT, indicated for symptomatic relief for Parkinson's Disease.

GENERAL ELECTRIC COMPANY, X-Ray Department
Milwaukee, Wisconsin — **Music Room—97**

A new Direct Writing Electrocardiograph and a new Short Wave Diathermy Unit as well as the Maxicon Diagnostic X-Ray Unit which is a member of the well-known building block line of diagnostic x-ray equipment will be seen at our booth.

GERBER PRODUCTS COMPANY — **Music Room—85**
Fremont, Michigan

Gerber's Concentrated Meat Base Formula is NEW. It is prepared to replace milk in the allergic infant's diet. Its use will help assure a well-fed and happy baby.

Your Gerber detailman looks forward to showing you this important infant food. He also invites you to examine the COMPLETE line of Strained and Junior foods including all-meat baby foods and four vitamin-enriched cereals. Up-to-date editions of Gerber's baby-care booklets are available for your office. . . . Complimentary, of course.

HARROWER LABORATORY, Inc. — **Ballroom—54**
Glendale

The Harrower technical exhibit will present Prulose Complex Tablets and Liquid, and Isocrin. These three products contain diacetylhydroxyphenylisatin, recently identified by Harrower research as the active laxative principle of California prunes. Pharmacological and clinical data are featured. Reprints, samples and literature will be supplied.

Room and Booth No.

H. J. HEINZ COMPANY — **Ballroom—56**
Pittsburgh, Pennsylvania

WHAT'S NEW AT THE HEINZ EXHIBIT? 1. Heinz Strained Orange Juice, Pre-cooked Rice Cereal, Strained Banana Custard Pudding, Junior Baked Beans. 2. Literature for your patients: "Strained Foods for Your Baby's Diet," "Junior Foods for Older Babies," "Recipe Magic Using Heinz Strained and Junior Foods." "Facts About Foods" includes caloric values and analyses of carbohydrates, protein, fat, calcium, sodium, iron and vitamins. 3. For office use: "Baby Gift Folders," "Nutritional Data," "Nutritional Observatory."

HOFFMANN-LA ROCHE, Inc. — **Ballroom Foyer—21**
Nutley, New Jersey

Be sure to ask about the new Gantrisin products when you visit the Roche display: GANTRICILLIN tablets—Gantrisin plus penicillin—for oral antibacterial therapy; and GANTRISIN NASAL SOLUTION—Gantrisin plus phenylephrine—to treat infection and relieve congestion.

Representatives at the Roche booth will be glad to answer questions concerning other Roche products which may be of interest to physicians.

HOLLAND-RANTOS COMPANY, Inc. — **Music Room—71**
New York, New York

You are cordially invited to inspect the Holland-Rantos display featuring: 1. Time-tested KOROMEX Diaphragms, Jelly, Cream, etc., *for dependable conception control*; 2. NYLMERATE Jelly and Solution Concentrate for effective low-cost treatment of trichomoniasis, moniliasis and nonspecific bacterial vaginitis. Representatives will welcome the opportunity to talk with you about H-R products of special interest to you.

IRWIN, NEISLER & COMPANY — **Music Room—66**
Decatur, Illinois

RESEARCH TO SERVE YOUR PRACTICE. We of Irwin, Neisler & Company believe that new drugs should not only pass the most rigid experimental and clinical tests, but should also *prove practical for the day to day practice of medicine.* At Booth 66 you will find new and improved practice-proven products for the management of cardiovascular disease, heart disease, bronchial asthma, obesity and other conditions with which you are confronted daily. Won't you stop by?

LANTEEN MEDICAL LABORATORIES, Inc.
Evanston, Illinois — **Music Room—76**

Lanteen Medical Laboratories, Inc., extend a cordial invitation to visit their Booth 76. The well-known line of Lanteen Gynecic Specialties will be available for discussion.

LEDERLE LABORATORIES — **Music Room—95**
New York, New York

You are cordially invited to visit our exhibit in Booth 95 where you will find representatives who are prepared to give you the latest information on LEDERLE products.

Room and Booth No.

LIEBEL-FLARSHEIM COMPANY — **Ballroom Foyer—23**
Cincinnati, Ohio

Kindly visit this Liebel-Flarsheim booth and see the latest and finest in Short Wave Diathermy and Office Bovie Electro Surgical equipment.

ELI LILLY AND COMPANY — **Ballroom—38**
Indianapolis, Indiana

You are cordially invited to visit the Lilly exhibit located in Booth 38. New antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly medical service representatives will welcome your questions about these and other recent therapeutic developments.

J. B. LIPPINCOTT COMPANY — **Ballroom—51**
Philadelphia, Pennsylvania

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

LOV-É BRASSIERE COMPANY — **Ballroom Foyer—19**
Hollywood

We invite you to inspect our highly specialized line of therapeutic breast supports which enable the physician to prescribe remedial support for specific breast conditions. Each Lov-é brassiere is custom-fitted inch-by-inch to your patient's personal measurements . . . and in exact accordance with your instructions. Special brassieres for prenatal, postpartum, atrophic, hypertrophic and mastectomy. Lov-é Corrective Brassieres are available in leading department stores and corset shops throughout the West. Our representative will be very happy to answer any questions.

M & R LABORATORIES — **Music Room—74**
Columbus, Ohio

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

MARLYN COMPANY, Inc. — **Music Room—91**
Los Angeles

Marlyn Co. Inc. cordially invites you to visit its exhibit which will feature Test-Estrin and other Marlyn specialties. Our representatives will be in attendance to provide information relative to our products, and any descriptive literature which you may desire.

THE S. E. MASSENGILL COMPANY — **Music Room—80**
Bristol, Tennessee

The Massengill exhibit will display Aminodrox, the tablet that makes it feasible to use oral aminophylline therapy in bronchial and cardiac asthma or angina pectoris. Other specialties will also be on display.

Room and Booth No.

McNEIL LABORATORIES, Inc. — **Ballroom—36**
Philadelphia, Pennsylvania

Members of the California Medical Association are cordially invited to visit our Booth 36. Mr. Hugh A. Harley in charge. Products to be featured are Butisol Sodium, Butisol-Belladonna, Syndrox Hydrochloride, Syntil, Cinbisal and Sustinex.

MEAD JOHNSON & COMPANY — **Ballroom Foyer—4**
Evansville, Indiana

Mead Johnson & Company, Evansville, Indiana, Booth 4, will feature the change in the formulation of Dextri-Maltose, the dried carbohydrate, designed especially for use in infant formulas. In addition to Natalins, small capsules containing vitamins and minerals, designed particularly for use in pregnancy and lactation; the Vi-Sols and four Pablum Cereals will be on display. Representatives in attendance will be glad to furnish information regarding the above products.

MEDCO PRODUCTS COMPANY — **Music Room—92**
Tulsa, Oklahoma

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

THE MEDICAL CENTER AGENCY — **Ballroom—30**
San Francisco

The Medical Center Agency cordially invites you to visit their booth. Experienced personnel will be in attendance.

Attractive opportunities for General Practitioners and Specialists available with Clinic Groups, individual associations, hospital assignments and locations. Complete information on qualified General Practitioners and Specialists desiring affiliations. Interviews strictly confidential.

We also supply experienced office personnel.

THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana — **Ballroom Foyer—15**

Specializing exclusively in Professional Protection since 1899, The Medical Protective Company provides representation at Booth 15, familiar with all the complexities of professional liability by special training and long experience. Answers to problems arising out of the Doctor-Patient relationship are available for the asking.

MERCK & CO, Inc. — **Ballroom Foyer—16**
Rahway, New Jersey

MERCK & CO., INC., is featuring CORTONE, HYDROCORTONE, NALLINE, and other medicinal preparations.

CORTONE has produced striking clinical improvement in rheumatoid arthritis and related rheumatic diseases; bronchial asthma; eye diseases including non-specific iritis, iridocyclitis and uveitis; and skin diseases including cases secondary to drug reactions.

HYDROCORTONE is recommended for injection into the articular cavity of a rheumatoid or osteoarthritic joint.

NALLINE is a specific antidote in the treatment of over-

dosage with morphine and its derivatives, as well as meperidine and methadone.

Representatives at the Merck booth will be glad to provide information on these and other medicinal preparations such as Antibiotics, NEO-ANTERGAN, URECHOLINE, and VINETHENE.

THE WM. S. MERRELL COMPANY — Ballroom—58

Cincinnati, Ohio

For prompt, effective and COMFORTABLE relaxation of gastrointestinal smooth muscle spasm, Merrell presents BENTYL Hydrochloride.

BENTYL is a high milligram potency non-narcotic antispasmodic with two-fold musculotropic and neurotropic action. Bentyl is therapeutically effective in functional gastrointestinal disorders without atropine-like side actions.

BENTYL is particularly suited for prolonged administration with habituation or increased tolerance.

MILLER SURGICAL COMPANY — Music Room—68

Chicago, Illinois

Sole manufacturers of Dr. Rudolph Gorsch's illuminated stainless steel rectal scopes. Proctologists, as well as other physicians interested in this field, will find it worth while to take a look. Other items of interest include their Electro-Scalpel which provides a unit for office, hospital and out-call use. It is thoroughly practical for all minor and light surgery and comes complete with monopolar electrodes for cutting, coagulating, desiccating, dehydrating and fulgurating in general work.

C. V. MOSBY COMPANY — Ballroom Foyer—1

San Francisco

You will find books on all subjects of interest to you at the Mosby Co. Booth 1. Come and look over whatever of these books you may care to. A company representative will be in attendance to assist you in any way that he can.

THE NATIONAL DRUG COMPANY — Ballroom—52

Philadelphia, Pennsylvania

The National Drug Company cordially invites you to visit their booth. On display you will find AVC Improved and Resion. AVC Improved is effective against an extremely wide range of vaginal tract infections. Resion offers a completely new approach in the treatment of diarrhea, food poisoning and the toxicity and irritation characteristic of bacterial gastrointestinal tract infections; also for controlling the nausea and vomiting of pregnancy.

THE NESTLE COMPANY, Inc. — Ballroom—45

White Plains, New York

You are cordially invited to visit the Nestle Booth 45 for information on Arobon, the antidiarrheal product, prepared from specially processed Carob flour. Literature and information on Nestle's milk products for infant feeding also will be available.

THE NETTLESHIP COMPANY — Ballroom Foyer—7

Los Angeles

Information on insurance problems of the doctor will be available to attending physicians.

The Nettleship Company has specialized in the field of the professional man for more than a quarter of a century, presently administering the official malpractice insurance programs of six County Medical Associations. It likewise serves nine professional organizations as administrators of their Group Accident and Sickness insurance programs. Many members of the profession have found it desirable to avail themselves of the services of the general insurance and life insurance departments of The Nettleship Company, due to the specialized attention given to the doctor's insurance needs.

ORTHO PHARMACEUTICAL CORPORATION

Raritan, New Jersey — Music Room—87

ORTHO cordially invites you to Booth 87 where the well-known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

PACIFIC COAST MEDICAL BUREAU, Agency

San Francisco — Ballroom—26

Pacific Coast Medical Bureau, Agency, San Francisco, will have representatives in Booth 26. This is the oldest medical bureau in the state and their many contacts assure you of prompt service if you wish a physician-surgeon in your offices, a specialist for a group or if you wish to relocate. Locations are checked for suitability. All services confidential. Drop by and say hello at Booth 26.

PELTON & CRANE CO. — Ballroom Foyer—20

Detroit, Michigan

A new, big PELTON HP-2 joins the pioneering, SPEEDY FL-2 for fast, effective autoclaving. This new autoclave is on display for the first time at this meeting of the California Medical Association and physicians are cordially invited to drop by our booth and see this new PELTON HP-2. Our representatives will be happy to discuss any and all Pelton products.

PET MILK COMPANY — Ballroom—57

San Francisco

The Pet Milk Company's display will feature the famous Collins quadruplets. We will have at our display all of the helpful services that the Pet Milk Company is so famous for in furnishing doctors in their practice.

CHARLES PFIZER & CO., Inc. — Ballroom—53

Brooklyn, New York

Terramycin, newest of the broad-spectrum antibiotics, forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

Room and Booth No.

PHILIP MORRIS & CO., Ltd., Inc. — **Ballroom Foyer—17**
New York, New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

PHYSICIANS ELECTRIC SERVICE CORP.
Los Angeles — **Ballroom Foyer—11**

Physicians Electric Service Corporation will display the Universal X-Ray, 100 MA/100 KVP, Rotating Anode Tube, the Beck-Lee Direct Writing Electrocardiograph and the Burdick FCC Approved Diathermy. You are cordially invited to visit our booth.

PICKER X-RAY — **Ballroom—42**
Los Angeles

We have for display the New Picker 60 Milliampere Mobile X-Ray unit equipped with a rotating anode tube. Also, New Picker-Polaroid Cassette and processing unit which will give you a flat, dry finished radiograph in 60 seconds.

PITMAN-MOORE COMPANY — **Music Room—73**
Indianapolis, Indiana

Pitman-Moore Company cordially invites all members and friends of the California Medical Association to visit its exhibit booth, 73. Polycin Ointment, Novahistine and Immune Serum Globulin, the most valuable aid in the control of paralytic poliomyelitis, will be featured. Mr. Paul Fledderjohn, Western Regional Manager, will be in charge of the company's exhibit.

A. H. ROBINS COMPANY, Inc. — **Music Room—89**
Richmond, Virginia

Physicians attending the California Medical Association Convention are extended a cordial invitation to visit the exhibit of the A. H. Robins Company, which is this year celebrating its 75th year of service to the medical profession.

Mr. Jack Farber and Mr. James Buman, Jr., will be in attendance to welcome you and answer inquiries relative to Robins' prescription specialties.

SANBORN COMPANY — **Ballroom—59**
Cambridge, Massachusetts

Latest-model Sanborn instruments for clinical diagnosis to be shown at Booth 59 will include the Viso-Cardiette, direct-writing electrocardiograph; and the Metabulator, self-enclosed metabolism tester. Complete data will also be available on the Sanborn Twin- and Poly-Visos, two- and four-channel Biophysical research recording systems; on the Sanborn Electromanometer, widely used instrument for physiologic pressure measurements; and on the new Sanborn Twin-Beam, two-channel recorder for simultaneous (or separate) recording of phonocardiograms and electrocardiograms.

Room and Booth No.

SANDOZ PHARMACEUTICALS — **Ballroom—47**
San Francisco

This display will feature Cafergot for the oral treatment of migraine; Methergine, an oxytocic; Cedilanid, a cardiac glycoside; Hydergine for essential hypertension and peripheral vascular disease, and Fiorinal for tension headache.

W. B. SAUNDERS COMPANY — **Ballroom—24**
Philadelphia, Pennsylvania

Some of Saunders' most recent publications on display for your inspection will be: *1953 Current Therapy;* new *Surgical Forum;* Todd, Sanford & Wells' *Clinical Diagnosis by Laboratory Methods*—12th edition; Banks & Laufman's *Atlas of Surgical Exposures of the Extremities;* Parsons & Ulfelder's *Pelvic Operations;* Beckman's *Clinical Pharmacology;* Dunphy & Botsford's *Physical Examination of the Surgical Patient;* Alexander's *Treatment of Mental Disorders;* and Sheldon, Mathews & Lovell's *Clinical Allergy.*

Also such standards works as Cecil-Loeb's *Textbook of Medicine;* Dorland's red-backed *Dictionary;* and the *Medical and Surgical Clinics of North America.*

R. L. SCHERER COMPANY — **Music Room—60**
Los Angeles

The R. L. Scherer Company will display the latest in Short Wave equipment—Burdick Electrograph—wire recorders, and items of interest to the profession.

SCHERING CORPORATION — **Ballroom—34**
Bloomfield, New Jersey

Members of the California Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Included in this exhibit will be Prantal, Methylsulfate, Schering, the first selective anticholinergic agent, and Dormison, the non-barbiturate hypnotic.

Schering representatives will be present to discuss with you these products as well as other products of our manufacture.

G. D. SEARLE & CO. — **Ballroom—55**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestril, the new synthetic estrogen for menopausal symptoms; Banthine, the true anticholinergic drug for the treatment of peptic ulcers, and Dramamine, for the prevention and active treatment of motion sickness.

SHARP & DOHME — **Ballroom—43**
Philadelphia, Pennsylvania

Research data relative to oral penicillin therapy is featured at the Sharp & Dohme technical display. The exhibit endeavors to justify reliance on oral penicillin for the therapy of the majority of penicillin treatable infections, excluding fulminating diseases requiring hospitalization. A resume of pharmacological attributes of certain nasal decongestants completes the exhibit. Expertly trained personnel will be present to discuss these observations.

Room and Booth No.

SMITH, KLINE & FRENCH LABORATORIES — **Ballroom—33**
Philadelphia, Pennsylvania

We extend a cordial invitation to you to visit our booth where 'Dexedrine' SPANSULES will be featured. Each capsule contains more than 100 tiny pellets with varying disintegration times. The 'Dexedrine' (15 mg.) is released gradually, yet uniformly, over a SPAN of 8 to 10 hours. Thus, in weight reduction, one 'Dexedrine' SPANSULE, taken on arising, curbs appetite evenly and effectively throughout the day.

E. R. SQUIBB & SONS — **Ballroom Foyer—22**
New York, New York

New Squibb products, and new brochures of useful interest to you on products already introduced, will be featured at Booth 22. As in former years, your Squibb representative again cordially invites you to visit the Squibb booth.

J. W. STACEY, Inc. — **Ballroom Foyer—13**
San Francisco

Stacey's, established over a quarter of a century ago by members of the medical profession, provides the doctor in the West with an efficient source for all medical books of all publishers. At Booth 13 you will find displayed the latest books on medicine, surgery, and the specialties. You are cordially invited to browse at your leisure.

STAYNER CORPORATION — **Ballroom Foyer—9**
Berkeley

Stayner cordially invites you to visit our booth where we will exhibit VIT-A-STAY, the latest development in Vitamin A therapy which affords better absorption, freedom from regurgitation and sensitivity. VIT-A-STAY tablets contain no oil of any kind to emulsify. We will also feature Stayner Placebo Capsules for barbiturate withdrawal therapy and demonstrate our fast-acting, water-soluble D.A.S. tablets for control of obesity. We will be happy to discuss any of the other 120 products of our manufacture or to merely have you use our booth as your headquarters.

THE STUART COMPANY — **Music Room—93**
Pasadena

The Stuart Company will present a general exhibit of Stuart products which are in the basic nutritional field. Among the products to be displayed are: Stuart Lipotaine, a new approach to lipotropic therapy based on the lipotrope, Betaine; Stuart Amvicel, a balanced formula containing the fine factors important for the control of obesity; and Stuart Normacid, a completely different and improved approach to the problem of Hydrochloric Acid-Pepsin Therapy. Other products in the Stuart line will also be displayed.

U. S. VITAMIN CORPORATION — **Ballroom—39**
New York, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research Laboratories.

Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops—multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solution, and now Vi-Aqua Syrup—aqueous multivitamins in candy-like syrup . . . for more rapid absorption, more certain utilization . . . no fish taste, odor, nor allergens.

We cordially invite you to our booth for detailed literature and professional samples.

THE UPJOHN COMPANY — **Ballroom—35**
Kalamazoo, Michigan

The importance of Cortisone is expanding as clinicians discover broadening uses. The scope of its application increases from month to month. The Upjohn Company is justly proud of its part in the development of Cortisone and in its discovery of new production methods. It is our aim to make Cortisone available to ever increasing numbers. Competent representatives welcome your inquiries and discussion.

VAISEY-BRISTOL SHOE CO., Inc. — **Music Room—67**
Monett, Missouri

Jumping Jacks are not represented as "corrective" shoes but rather as a nearer equivalent to the healthfulness of going barefooted. Representatives will show how the footprint which develops on the soles of Jumping Jacks provides a case history of the individual foot function of the child. Representatives will also show examples of Dr. Henry A. Sincock's adhesive tape wedging of shoes.

VARICK PHARMACAL CO., Inc. — **Ballroom—32**
New York, New York

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

WALKER LABORATORIES, Inc. — **Music Room—79**
Mount Vernon, New York

HEDULIN is a new oral anticoagulant, rapid-acting, economical and substantially safe for treatment in hypoprothrombinemia. Council-Accepted HEDULIN differs chemically from oral anticoagulants in general use. It is not a coumarin derivative and is unlikely to induce the adverse effects often attributed to this class of compounds. Clinical investigation has shown this drug to be free from cumulative effects, rapid-acting and with the favorable characteristic of returning prothrombin time to normal within 24 to 48 hours after withdrawal.

HEDULIN is available in uncoated tablets each containing 50 mg. of Phenindione. The initial dose should be 200 to 300 mg. of HEDULIN with a maintenance dose of 50 to 100 mg. per day in each case. After establishment of maintenance dose, prothrombin time determination is required only once in 7 to 14 days.

WALTERS SURGICAL COMPANY — **Ballroom Foyer—5**
Los Angeles

We will exhibit the latest X-Ray and Physiotherapy equipment made by H. G. Fischer & Company. Also, the newly designed Cardiotron Electrocardiograph and new surgical items of general interest.

Room and Booth No.

WARREN-TEED PRODUCTS CO. — **Ballroom—44**

Columbus, Ohio

The Warren-Teed Products Company cordially invites you to visit their exhibit at Booth 44. Sinan (Brand of Mephenesin Warren-Teed) used in the treatment of certain spastic and neuromuscular disorders will be featured at this exhibit. Courteous representatives will be in attendance to assist registrants in any way possible.

WESTERN SURGICAL SUPPLY COMPANY

Los Angeles — **Music Room—62, 63**

The Western Surgical Supply Company of Los Angeles and San Francisco will have on display many physicians' supply instruments including examining room furniture, sterilizing equipment, electric equipment, Birtcher-Bandmaster-Diathermy, hypodermic syringes and needles and many other items for use in a doctor's office. You are cordially invited to visit our booth.

WESTINGHOUSE ELECTRIC CORPORATION

Baltimore, Maryland — **Ballroom Foyer—8**

WESTWOOD PHARMACEUTICALS — **Music Room—82**

Buffalo, New York

Westwood displays its vaginal anti-infectives Gentia-Jel and Westhiazole—now packaged in plastic single-dose disposable applicators.

These plastic applicators make possible antimycotic therapy in the office and at home, with gentian violet—without the mess and inconvenience usually associated with this specific moniliacide. Demonstrations will be made at the Westwood booth.

WHITE LABORATORIES, Inc. — **Ballroom—37**

Kenilworth, New Jersey

DIENESTROL—the potent, orally effective synthetic estrogen—differs chemically from stilbestrol and other synthetic estrogens. It is unique in its action and is one of the best tolerated of all orally effective synthetic estrogens.

GITALIGIN has been described as a ". . . digitalis preparation of choice."

COD LIVER OIL CONCENTRATE LIQUID provides economical and convenient dosage of vitamin A and D—each drop equivalent to one teaspoonful of cod liver oil in vitamin D content. The vitamin A and D are present in a 5:1 ratio. Also available as palatable "candy-tasting" tablets and soft gelatin capsules which provide high potency medication.

White Laboratories representatives will gladly welcome physicians at Booth 37 to discuss with them the above-listed products.

WINTHROP-STEARNS, Inc. — **Ballroom—40**

New York, New York

Winthrop-Stearns, Inc., New York, extends a cordial invitation to visit Booth 40, where the following products will be featured: TELEPAQUE, the new, highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear-cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts; LEVOPHED, the true vasoconstrictor hormone of the Adrenal Medulla, for the maintenance of blood pressure in shock and other acute hypotensive states; MILIBIS SUPPOSITORIES, new, highly effective specific against trichomonal, monilial, bacterial (nongonococcal) and mixed vaginitis.

WYETH LABORATORIES — **Ballroom Foyer—10**

Philadelphia, Pennsylvania

You are cordially invited to visit the Wyeth display, which will feature: S-M-A,® the modern, perfectly balanced infants' formula that is unsurpassed in similarity to human milk and Thiomerin,® the recently developed, effective mercurial diuretic that produces an even and persistent fluid loss without drastically depleting effects. It is particularly adaptable to self-administration. Representatives will be on hand to discuss and supply literature concerning these and other widely prescribed Wyeth ethical specialties.

OFFICERS AND DELEGATES

General Officers

L. A. ALESEN, Los Angeles.....President
JOHN W. GREEN, Vallejo.....President-Elect
DONALD A. CHARNOCK, Los Angeles.....Speaker of House of Delegates
WILBUR BAILEY, Los Angeles.....Vice-Speaker of House of Delegates
SIDNEY J. SHIPMAN, San Francisco.....Chairman of Council
ALBERT C. DANIELS, San Francisco.....Secretary
DWIGHT L. WILBUR, San Francisco.....Editor
JOHN HUNTON, San Francisco.....Executive Secretary
PEART, BARATY & HASSARD.....Legal Counsel

Members of House of Delegates—50th Annual Session

TOTAL DELEGATES (284)

DELEGATES EX OFFICIO (33)

L. A. Alesen, Los Angeles.....President
John W. Green, Vallejo.....President-Elect
Donald A. Charnock, Los Angeles.....Speaker of House of Delegates
Wilbur Bailey, Los Angeles.....Vice-Speaker of House of Delegates
Albert C. Daniels, San Francisco.....Secretary-Treasurer
Dwight L. Wilbur, San Francisco.....Editor
Francis E. West (1955).....Councilor 1st District
Omer W. Wheeler (1953).....Councilor 2nd District
H. Clifford Loos (1954).....Councilor 3rd District
J. Philip Sampson (1955).....Councilor 4th District
A. A. Morrison (1953).....Councilor 5th District
Neil J. Dau (1954).....Councilor 6th District
Hartzell H. Ray (1955).....Councilor 7th District
M. Laurence Montgomery (1953).....Councilor 8th District
Donald D. Lum (1954).....Councilor 9th District
Warren L. Bostick (1955).....Councilor 10th District
Wayne E. Pollock (1953).....Councilor 11th District

ELECTED DELEGATES (251)

Alameda-Contra Costa County (21)

Delegates	*Alternates*
Dorothy M. Allen	Herman Allington
Cyril J. Attwood	J. C. Bartlett
James A. Barr	Merle Buehler
Philip N. Baxter	R. Abbott Crum
K. W. Benson	Kaho Daily
John Blum	Floyd Due
Edwin Clausen	David J. Dugan
Thomas J. Dozier	Homer Fornoff
Grant Ellis	Claude Forbush
L. H. Fraser	Malcolm Hadden
Bernard B. Gadwood	Frank Haight
James B. Graeser	George S. Irvine
Ernest W. Henderson	H. P. Maloney
William Kaiser	James Raphael
Lester Lawrence	Robert L. Redfield
Robert S. Leet	Thomas T. Rolleri
Noble Logan	Joseph Sadusk
James Reavis	P. R. Shumaker
T. E. Reynolds	Helen Jean Snook
Maxwell Thebaut	Stuart Stephens
Stanley R. Truman	Dan Tucker

Butte-Glenn County (2)

Marvin Chernow	Donald Casey
Frank I. O'Neill	Thomas Elmendorf

Fresno County (5)

Verne Ghormley	J. M. Arthur
E. C. Halley	H. M. Ginsburg
Henry A. Randel	Arthur Howard
Eliot Sorsky	George Olson
J. E. Young	Robb Smith

Humboldt County (2)

O. R. Myers	Fred A. Olson
Francis H. O'Neil	Joseph S. Woolford

Imperial County (2)

Charles M. Cutshaw	Jack R. Bostwick
Frederick Powers Heald	George C. Holleran

Inyo-Mono County (2)

C. C. Curtis	Lloyd S. Bambauer
Clarence L. Scott	George Shultz

Kern County (3)

Roderick A. Ogden	Robert Douds
Robert A. Patrick	Carl L. Moore
J. E. Vaughan	Raymond W. Owens

Kings County (2)

W. S. Bridwell	Paul Brothers
William F. Chamlee	Lloyd Christensen

Lassen-Plumas-Modoc County (2)

Roy M. Peters	R. A. Greenman
William Quinn	Paul McKinney

Delegates	*Alternates*
Los Angeles County (94)	
Marden A. Alsberge	John D. Abbey
E. Vincent Askey	Lawrence Adams
Elmer J. Ball	Herbert J. Andrews
Franklin I. Ball	Arthur T. Bailey
Madelene Beckenbach	Francis J. Baker
Earl J. Boehme	Reid L. Beers
Lewis T. Bullock	Danield Beltz
Behle B. Burns	George E. Bien
L. C. Burwell	Linus H. Bittner
Marvin Calmenson	Robert L. Blackmun
Robert V. Carter	Jesse L. Block
Tenero D. Caruso	Peter H. Blong
Donald Cass	Harold Boyd
William C. Clough	Fred E. Bradford
R. Wendell Coffelt	James L. Bray
Wells C. Cook	Donald Brayton
Clair P. Cosgrove	David J. Brobeck
Jay B. Cosgrove	George E. Brown
William E. Costolow	Arthur H. Buell
Lyle G. Craig	Walter Buerger
Edward H. Crane, Jr.	John A. Bullis
Jay J. Crane	Norman L. Cardey
Verne C. Crowl	John L. Caster
Philip J. Cunnane	Rafe C. Chaffin
Rynol A. Dahlman	John G. Champion
Dean C. Denman	Merwin Reid Chappel
Leon O. Desimone	James G. Conti, Jr.
M. A. Desmond	Harold E. Crowe
Harry F. Dietrich	J. W. Dassett
John W. Dorsey	Charles L. Davis
James C. Doyle	Douglas Donath
Frederic Ewens	A. Keith Droz
Gaylord Fisher	Lewis F. Elmore
Robbin E. Fisher	Wells E. A. Forde
Paul D. Foster	Vernon W. Foster
Thomas M. Gairdner	Robert G. Freeman
Mark Giffords	William A. Gannon
Robert B. Haining	Garland F. Garrett
Dorothy Hewitt	Frederic J. Gaspard
John W. Higgins	Wallace G. Gilbert
Eugene F. Hoffman	Charles Gilfillan
Elizabeth Mason Hohl	McCleery Glazier
Howard P. House	Elmer F. Gooel
Louis L. Huff	George W. Groth, Jr.
John B. James	Victor E. Hallstone
Fordyce Johnson	John B. Hamilton
Julius Kahn	Bernard J. Harvey
Bennett W. Kantola	Walter L. Haworth
Thomas R. Kidd	Robert Helms
Arthur A. Kirchner	Alfred G. Henrich
George L. Kraft	Robert B. Hope
E. R. Lambertson	L. Dale Huffman
Arthur John Langan	Willis L. Jacobus, Jr.
Thomas A. LeValley	George E. Judd
Karl Lewis	Thomas A. Kendig
J. Lafe Ludwig	T. J. Laughlin
Edgar F. Mauer	O. Dale Lloyd
Angus McDonald	Robert A. Lovell
Oliver Moore	Douglas R. MacColl
Carl L. Mulfinger	Walter P. Martin
Joseph P. O'Connor	June P. McBride
J. Norman O'Neill	John B. McDonald
Frank W. Otto	Edwin E. McNiel
W. DeGrove Padgett	Clement J. Molony
Donald W. Pettis	Alexander A. Mueller
Merl Lee Pindell	E. J. Mueller, Jr.
F. M. Pottenger, Jr.	Roderick M. Neale
Hubert J. Prichard	Edward F. Nippert
Myron Prinzmetal	Edward C. Pallette
William F. Quinn	Donald D. Parker
James F. Regan	Ross V. Parks
E. T. Remmen	Edwin B. Plimpton
J. M. de los Reyes	Charles T. Poulson
Edward C. Rosenow, Jr.	Morton H. Randall
Phillip L. Rossman	Chester L. Roberts
Eric A. Royston	Ward M. Rolland
John C. Ruddock	Irving Rosenberg
Ralph L. Schroeder	Fred Schlumberger
Arthur H. Schwartz	Robert M. Shelton
Walter Scott	Bernard H. Smith
J. Edward Short	Earl H. Smith
Ralph Varian Sloan	William H. Snyder
Gordon K. Smith	Harold D. Spickerman
Justin J. Stein	Norman F. Sprague, Jr.
G. Arnold Stevens	Karl P. Stadlinger
William J. Tennison	Packard Thurber, Jr.
Clinton H. Thienes	Paul E. Travis
Malcolm Todd	George G. Verbryck
Ewing L. Turner	Leon R. Walker
H. Milton Van Dyke	Charles W. Ware
E. E. Wadsworth, Jr.	F. C. Westerhout
Warren A. Wilson	John W. Whitsett
Harold R. Witherbee	Lawrence A. Williams
William T. Zimmermann	J. Walter Wilson
Madera County (2)	
Omar Need	Gilbert Daggett
Coe T. Swift	L. A. Solberg
Marin County (2)	
Edward Campion	Arnold Nutting
William B. Smith	Leo L. Stanley
Mendocino-Lake County (2)	
Thomas P. Hill	Charles Craig
James B. Massengill	Robert B. Smalley
Merced County (2)	
Shelby Hicks	A. B. Bigler
George Pimentel	Avery Sturm
Monterey County (2)	
James H. McPharlin	Howard C. Miles
Ernest E. Simard	Allen Conrad Mitchell
Napa County (2)	
Dale E. Barber	Donald B. Marchus
Walter H. Brignoli	H. B. Messinger
Orange County (4)	
A. Norton Donaldson	Harold F. Galbraith
Arthur J. Nies	Samuel Gendel
J. B. Price	Milton M. Maxwell
L. E. Wilson	William Owen
Placer-Nevada-Sierra County (2)	
Harry March	Max Dunievitz
William M. Miller	Saul Ruby
Riverside County (2)	
William Aikin	James C. Long
Franklin B. Mead	Walter J. Wood
Sacramento County (5)	
Dave F. Dozier	Charles E. Grayson
Dan O. Kilroy	A. M. Henderson, Jr.
Milton V. Sarkisian	Frank A. MacDonald
Ralph Teall	Charles J. Wallace
James H. Yant	Raymond M. Wallerius
San Benito County (2)	
John J. Haruff	R. E. Brown
Eberle Sheldon	E. N. Moore
San Bernardino County (5)	
John H. Coughlin	Charles J. Clock
Carl M. Hadley	Joseph S. Hayhurst
J. Needham Martin	Gordon L. Helstrom
E. L. Tisinger	Frank C. Melone
Roger A. Vargas	Leonard M. Taylor
San Diego County (11)	
Douglass H. Batten	Walter F. Carpenter
H. G. Holder	Patricia E. Dunklee
Frederick G. Hollander	Charles R. Hyde
Roger C. Isenhour	Ralph M. King
Arthur A. Marlow	Robert Loveall
A. E. Moore	Roy A. Ouer
Willard H. Newman	James R. Phalen
Ross C. Pyle	James W. Ravenscroft
Frank H. Robinson	W. T. Soldmann
John M. Rumsey	Calvin L. Stewart
Joseph W. Telford	Chester Tancredi
San Francisco County (29)	
Dorothy W. Atkinson	Douglas G. Campbell
Walter Beckh	Donald A. Carson
William L. Bender	Roy B. Cohn
Donald M. Campbell	Robert C. Combs
George Campion	Roberta F. Fenton
Garnett Cheney	Francis T. Hodges
Francis J. Cox	William C. Kuzell
Frederick A. Fender	E. Donald Lastreto
Kenneth D. Gardner	Charles A. Noble, Jr.
L. Henry Garland	Frank Norris
Henry Gibbons III	Mary B. Olney
Harold E. Hand	Leon O. Parker
Allen T. Hinman	Agnes G. Plate
Alson R. Kilgore	Victor Richards
Russell R. Klein	Abraham B. Sirbu
Carleton Mathewson, Jr.	Merrell A. Sisson
Joseph S. McGuinness	Curtis E. Smith
Stacy R. Mettier	Francis Scott Smyth
Herbert C. Moffitt, Jr.	Vance M. Strange
Edmund J. Morrissey	James H. Thompson
Francis Rochex	Emile D. Torre
William L. Rogers	Lawrence M. Trauner
Karl L. Schaupp, Jr.	William W. Washburn
Samuel R. Sherman	Harry Weinstein
Henry L. Silvani	Philip R. Westdahl
August Spitalny	Forrest M. Willett
Grace M. Talbott	Henry B. Woo
Robertson Ward	Reuben Zumwalt
Helen B. Weyrauch	

Delegates	*Alternates*
San Joaquin County (3)	
Louis P. Armanino	J. Frank Doughty
Jack Eccleston	Edmund P. Halley
Neill P. Johnson	James R. Powell
San Luis Obispo County (2)	
Charles R. Kennedy	Edward Blair
Robert O. Pearman	Laurence C. Gaebe
San Mateo County (6)	
James S. Edwards	Charles D. Armstrong
Thomas E. Farthing	C. D. Benninghoven
Logan Gray	Bradley C. Brownson
Ralph D. Howe	Philip S. Geller
A. G. Miller	George J. Laird
Frederic P. Shidler	Harry F. Smith
Santa Barbara County (3)	
J. Gary Campbell	Hugh F. Freidell
Arthur E. Wentz	David L. Reeves
Alfred B. Wilcox	L. K. Thacher
Santa Clara County (8)	
Burt Davis	Lee Blanchard
Thomas N. Foster	Albert R. Currlin
Leon P. Fox	J. D. Lamon
J. B. Josephson	Robert A. Loehr
Leslie B. Magoon	Gabe Long
William L. Molineux	Ansten R. Ness
Paul V. Morton	Sydney Thomas
John C. Wilson	George Waters
Santa Cruz County (2)	
Luther Newhall	J. A. Ludden
Samuel B. Randall	Lorin Siegel
Shasta County (2)	
Roland R. Jantzen	Julius Kehoe
George A. Martin	Joe L. Price
Siskiyou County (2)	
James B. McGuire	Eugene V. Anderson
Albert H. Newton	Harry L. Vidricksen
Solano County (2)	
John Garthe	F. Burton Jones
Lionel Johnson	Felix J. Rossi, Jr.

Delegates	*Alternates*
Sonoma County (2)	
Leonard W. Hines	John J. Mohrman
Horace F. Sharrocks	Donovan C. Oakleaf
Stanislaus County (2)	
R. Stewart Hiatt	M. C. Collins
Edward K. Prigge	George S. Feher
Tehama County (2)	
R. G. Frey	A. H. Meuser
Frank Townley	O. T. Wood
Tulare County (2)	
James E. Feldmayer	C. H. Johnson
Robert D. Karstaedt	Ralph N. Miller
Ventura County (2)	
Franklin K. Helbling	Richard Reynolds
J. W. Moore	Woodrow W. Schmela
Yolo County (2)	
Thomas Y. Cooper	James H. Kimbell
John G. O'Hara	Max Waters
Yuba-Sutter-Colusa County (2)	
Stanley R. Parkinson	Charles B. Kimmel
Francis P. Wisner	Joseph J. Salopek

Past Presidents (16)

George H. Kress.....1916
Edward N. Ewer.....1925
Lyell C. Kinney.....1930
Junius B. Harris.....1931
George G. Reinle.....1933
Robert A. Peers.....1935
Harry H. Wilson.....1940
William R. Molony, Sr.....1942
Karl L. Schaupp.....1943
Lowell S. Goin.....1944
Sam J. McClendon.....1946
John W. Cline.....1947
E. Vincent Askey.....1948
R. Stanley Kneeshaw.....1949
Donald Cass.....1950
H. Gordon MacLean.....1951

House of Delegates Agenda

1953 Annual Session

Renaissance Room, Biltmore Hotel

Speaker.....Donald A. Charnock, Los Angeles
Vice-Speaker.....Wilbur Bailey, Los Angeles
Secretary.....Albert C. Daniels, San Francisco

FIRST MEETING

Sunday, May 24, 1953, at 9:30 a.m.

ORDER OF BUSINESS

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (a) Committee on Credentials. (Delegates must register with the Committee.)
   (b) Reference Committee on the Reports of Officers, the Council and Standing and Special Committees. (Reference Committee No. 1.)
   (c) Reference Committee on Finance, to review the reports of the Secretary-Treasurer and the Executive Secretary and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year (Reference Committee No. 2.)
   (d) Reference Committee on Resolutions and New and Miscellaneous Business. (Reference Committee No. 3.)
   (e) Reference Committee on Amendments to the Constitution and By-Laws. (Reference Committee No. 4.)
   (f) Reference Committee on C.P.S. business.
5. Address by President Lewis A. Alesen.
   Presentation of 50-Year-Awards.
6. Miscellaneous announcements by the Speaker. (Stenographic service, to secure triplicate copies of resolutions, etc.)
7. Report of the President—Lewis A. Alesen.
8. Report of the President-elect—John W. Green.
9. Report of the Speaker of the House of Delegates—Donald A. Charnock.
10. Report of the Vice-Speaker—Wilbur Bailey.
11. Report of the Chairman of the Council—Sidney J. Shipman.
12. Report of the Council—Sidney J. Shipman.
13. Report of the Trustees of the California Medical Association—Lewis A. Alesen, President.
14. Report of the Secretary—Albert C. Daniels.
15. Report of the Treasurer—Albert C. Daniels.
16. Report of the Executive Secretary—John Hunton.
17. Report of the Editor—Dwight L. Wilbur.
18. Reports of District Councilors.
19. Reports of Councilors-at-Large.
20. Report of Legal Counsel—Peart, Baraty & Hassard.
21. Report of C.P.S. Board of Trustees.
22. Reports of Standing and Special Committees:
   A. Standing Committees:
   (a) Executive Committee—Donald D. Lum.
   (b) Committee on Associated Societies and Technical Groups—Robert A. Scarborough.
   (c) Auditing Committee—Donald D. Lum.
   (d) Committee on History and Obituaries—Dewey R. Powell.
   (e) Committee on Hospitals, Dispensaries, and Clinics—John B. Hamilton.
   (f) Committee on Industrial Practice—Raymond M. Wallerius.
   (g) Committee on Medical Defense—H. Clifford Loos.
   (h) Committee on Medical Economics—Leopold H. Fraser.
   (i) Committee on Medical Education and Medical Institutions—Lewis T. Bullock.
   (j) Committee on Military Affairs and Civil Defense—Justin J. Stein.
   (k) Physicians' Benevolence Committee—Axcel E. Anderson.
   (l) Committee on Postgraduate Activities—Edward C. Rosenow, Jr.
   (m) Committee on Public Policy and Legislation—Dwight H. Murray.
   (n) Committee on Public Relations—Ed Clancy.
   (o) Committee on Scientific Work (Annual Session)—Albert C. Daniels.
   (p) Cancer Commission—Ian G. Macdonald.
   (q) Editorial Board—Dwight L. Wilbur.
   B. Special Committees:
   (a) Delegates to the American Medical Association—E. Vincent Askey.
   (b) Advisory Planning Committee—John Hunton.
   (c) Blood Bank Commission—John Upton.
   (d) C.P.S. Liaison Committee—Lewis A. Alesen.
   (e) C.P.S. Study Committee—Wilbur Bailey.
   (f) Medical Services Commission—Leslie B. Magoon.
   (g) Committee on Industrial Health—Christopher Leggo.
   (h) Committee on Rural Medical Service—Henry A. Randel.
   (i) C.P.S. Fee Schedule Committee—DeWitt K. Burnham.

23. Report of Reference Committee No. 1—1952 Interim Session.
24. Report of Reference Committee No. 3—1952 Interim Session.
25. Report of Reference Committee No. 4—1952 Interim Session.
26. Old and Unfinished Business.
27. New Business.

SECOND MEETING

Wednesday, May 27, at 9:30 a.m.

Order of Business

1. Call to order.
2. Supplemental report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1954 annual session.
5. Election of Officers:
   (a) President-elect.
   (b) Speaker.
   (c) Vice-Speaker.
   (d) District Councilors (three-year term):
      1. Second District—Omer W. Wheeler, Riverside (term expiring).
         Second District—Imperial, Inyo, Mono, Orange, Riverside and San Bernardino counties.
      2. Fifth District—A. A. Morrison, Ventura (term expiring).
         Fifth District—Ventura, San Luis Obispo, Santa Barbara and Ventura counties.
      3. Eighth District—M. Laurence Montgomery, San Francisco (term expiring).
         Eighth District—San Francisco County.
      4. Eleventh District—Wayne E. Pollock, Sacramento (term expiring).
         Eleventh District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba counties.

   (e) Councilors-at-Large (three-year terms):
   Sidney J. Shipman, San Francisco (term expiring).
   Arthur A. Kirchner, Los Angeles (term expiring).

   (f) Delegates to American Medical Association:
   Delegates and Alternates to the American Medical Association are elected for terms of two calendar years. The Delegates and Alternates to be elected at this meeting will serve for two calendar years ending December 31, 1955.
   Incumbents:
      (a) Robertson Ward, San Francisco (term expiring).
      (b) Sam J. McClendon, San Diego (term expiring).
      (c) Eugene F. Hoffman, Los Angeles (term expiring.)
      (d) John W. Green, Vallejo (term expiring).
      (e) Lewis A. Alesen, Los Angeles (term expiring).
      (f) Frank A. MacDonald, Sacramento (term expiring).

   (g) Alternates to American Medical Association:
   Incumbents:
      (a) Henry Gibbons III, San Francisco (alternate to Robertson Ward).
      (b) A. E. Moore, San Diego (alternate to Sam J. McClendon).
      (c) Frederic S. Ewens, Manhattan Beach (alternate to Eugene F. Hoffman).
      (d) Orris R. Myers, Eureka (alternate to John W. Green).
      (e) J. B. Price, Santa Ana (alternate to L. A. Alesen).
      (f) Henry A. Randel, Fresno (alternate to Frank A. MacDonald).
6. Election of C.P.S. Trustees:
   Report of C.M.A. Council as Nominating Committee.
   Incumbents:
   (a) Donald Cass, Los Angeles.*
   (b) Kendrick A. Smith, Los Angeles.*
   (c) Francis T. Hodges.
   (d) Mr. Robert A. Hornby.
   (e) Vacancy in office — resignation of Harold M. F. Behneman.
7. Election of two members to C.M.A.-C.P.S. Liaison Committee.
8. Announcement by Secretary.
   Council's nominations of members of Standing Committees (for approval by the House of Delegates).
9. Reports of Reference Committees:
   (a) Report of Reference Committee No. 1 on Reports of Officers, the Council, and Standing and Special Committees.
   (b) Report of Reference Committee No. 2 on Reports of the Secretary-Treasurer and the Executive Secretary, on budget and dues.
   (c) Report of Reference Committee No. 3 on Resolutions and New and Miscellaneous Business.
   (d) Report of Reference Committee No. 4 on Amendments to the Constitution and By-Laws.
   (e) Report of Reference Committee on C.P.S. business.
10. Unfinished Business.
11. New Business.
12. Presentation of Officers:
   President
   President-Elect
   Speaker
   Vice-Speaker
13. Presentation of Certificate to Retiring President—Lewis A. Alesen.
14. Approval of Minutes. (Committee to edit.)
15. Adjournment.

Donald A. Charnock, *Speaker*
Albert C. Daniels, *Secretary*

* Has served two consecutive terms; not eligible for reelection.

PRE-CONVENTION REPORTS

Officers • Councilors • Committees • County Societies

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the California Medical Association and the House of Delegates:

It is proper that the officers of an organization should on occasion report upon their stewardship. Such a report by the president ought to concern itself with the broad aims and objectives of the organization, the extent to which those aims have been achieved, and the extent to which such achievement has failed. In addition, it would seem mandatory for such a report to stress the imminent threats to the ideals of the organization and their consummation and to offer in so far as is possible constructive suggestions of methods designed to meet those threats.

During the two years just past, it has been my high privilege to visit our county medical societies in every section of the vast state of California. With a membership exceeding 11,000 doctors of medicine practicing the healing art in large cities, smaller towns, and sparsely populated rural areas, there are naturally differences in particular problems confronting the individual physician and his county medical society. Significantly enough, however, all of these physicians have one objective in common, that is to make available to their patients the highest possible grade of medical care and to render that care within the ability of the patient to pay for it. In the rural areas great interest is manifested in the postgraduate programs, the one request being most often heard was that such programs might be enlarged and offered more frequently.

In most county societies the Woman's Auxiliary is an important component part of local activities. These women participate in women's clubs, church organizations, and civic movements of all kinds. They are alert, intelligent, aggressive, and wish only to know what the parent county association desires in the way of assistance, and they are only too happy to roll up their sleeves and go to work. As the result of this attitude, our Woman's Auxiliary to the California Medical Association, under the capable leadership of Mrs. Raleigh W. Burlingame, is one of our most important fighting arms. This year its program has been built around the slogan: "Reclaim Freedom in America."

The Association's fiscal affairs are in good condition. Under the able direction of Secretary-Treasurer Dr. Albert C. Daniels, aided by the Executive Committee under the chairmanship of Dr. Donald D. Lum, a careful audit of the Association's expenditures is periodically made. The central office at 450 Sutter Street under the excellent management of Executive Secretary Mr. John Hunton, operates smoothly and efficiently. Our employees are loyal and genuinely interested in their work.

CALIFORNIA MEDICINE, under the editorship of Dr. Dwight L. Wilbur, is rapidly being recognized as one of the outstanding state publications.

Our Public Relations Department, under the direction of Mr. Ed Clancy, ably assisted by associates Mr. Jerry Pettis and Mr. Glenn Gillette, has prepared a master plan for grass-roots public relations by the county societies and has gone into every area where requested to assist the county officers in these plans.

Dr. Dwight H. Murray and his capable Committee on Public Policy and Legislation aided and abetted by Mr. Ben H. Read, executive secretary of the Public Health League, and many others represent us at Sacramento the year around. A trip to the state capital impresses one with the high esteem in which our representatives are held by assemblymen, senators, and business and professional representatives alike. Over the years this type of representation has gained for us an enviable reputation and has brought requests to assist the Legislative Budget Committee in an analysis of the value of certain projects in the field of medicine.

Legal Counsel Howard Hassard is an institution in himself. To the extent that he can, he practices prophylactic law for his client, the California Medical Association, keeping us out of trouble most of the time, and skillfully extracting us from it on other occasions.

Too much praise and credit cannot be given to our Councilors, under the skillful leadership of Dr. Sidney J. Shipman, members of our commissions, and standing and special committees, who really perform the important foundation work of the Association and ferret facts in making recommendations to be considered in determining Association policy.

Because the threat of compulsory health insurance or political medicine seems momentarily and to a limited extent only to have been contained, we should not be blinded to other threats to medical freedom, merely because they seem to arise under different auspices, and seem, so their sponsors state, motivated by the highest of ideals. I refer, to be specific, to the rapid growth of (1) subsidized closed-panel systems of medical care, and (2) to the threat of labor organizations to enter the field of medical care through the widespread system of salaried physicians and elaborate health centers. A little careful analysis of the proposals underlying both of these plans will result inescapably in the realization that the ultimate objective is a complete monopoly over the rendition of medical care, and therefore, of course, ultimately a complete abolition of freedom for the practitioner as well as for his patient. In my view, it would make very little difference whether such an absolute monopoly were achieved by an interlocking directorate of business tycoons uttering reams of pious platitudes while at the same time destroying the private practitioner by the same old squeeze play which caused Judge Kenesaw Mountain Landis to dissolve the Standard Oil Corporation in 1908; or a monopoly over medical care achieved by the power-hungry labor leader whose featherbedding tactics have added 20 per cent to the cost of every good and service produced in this country, and who looks upon the physician as just another plum ripe for the picking; or a similar type of monopoly exercised by the cold leprous fingers of bureaucracy. Monopoly in medicine is just as bad for the ultimate consumer, the patient, and the purveyor, the physician and his associates, as it is for the consumer and producer of every other useful good and service throughout our economy as a whole.

The answer to these threats? There is no pat or simple one. It, of course, is trite and obvious to say that we must

make our own system of private medical care so attractive, make it operate so efficiently, place it within the means of everyone so completely by virtue of our voluntary prepayment plans that the monopolist will find no ready market for his wares. The Special Study Committee on California Physicians' Service has done a monumental piece of work and reported its findings at the Interim Session of the House of Delegates in San Francisco in December. Further discussion of this report is to be held at the May meeting. As the result of one of the recommendations of the Special Study Committee, the House of Delegates of the California Medical Association is now the House of Delegates of the California Physicians' Service, and there is a closer liaison between the parent and daughter organization. The Medical Services Commission, a permanent body authorized by the House of Delegates, is beginning its investigation into every phase of the prepayment of the costs of illness and will have some positive and constructive recommendations to make toward improving our services to the public. Private insurance companies are evidencing an interest in the field of medical care greater than ever before and have been more ready than ever to discuss with us the operation of indemnity plans, all offering unlimited freedom of choice to patient and physician alike. These are good selling points but they are not spectacular.

Once again, it is repetitious to state that medical economics is just one phase of the broad problem of economics as a whole. As physicians we must insist with all the intelligence and force at our command that the only healthy economy is the productive economy, the economy in which there are available the greatest abundance and variety of goods and services to everyone living within it, and an environment in which every individual is stimulated to produce to his utmost, to contribute, and to accumulate, thereby developing to the greatest possible degree his God-given talents. We must insist that any attitude or measure that in any manner interferes with the production, distribution, and consumption of goods and services in any field whatsoever interferes with the economic and social well-being of every member within the economy. We must appraise every proposed social change by one rule of thumb. What does it do to the human individual? Does it make him more or less dependent upon himself?

Upon this rock-bottom of fundamental principles we are in a position to participate widely in the economic and social structure as citizens as well as physicians, and to demonstrate that good medical care, like all of the other good things of this life, is just one of the enviable products of the American system of profit and loss or private competitive enterprise. In that system the only justifiable function of government is to protect the individual in the enjoyment and the accumulation of the fruits of his labor.

Respectfully submitted,

L. A. ALESEN, *President*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

It has been pleasant and instructive to meet with twenty-one county medical society groups as well as some Auxiliary bodies and to carry the message of our profession to our constituents. We have stressed better public relations, 24-hour service to the sick and injured, interest in legislation affecting the practice of medicine in its local, state, national and international aspects and have assisted the president, wherever possible. We have mentioned the needs of the American Medical Education Foundation, in order that we may keep our medical colleges free of federal influence and control. Our interest must continue in the problem of recruitment for nursing schools and we have emphasized that fees for service shall be based upon the ability of the patient to pay. We have attended all meetings of the Council and of the Executive Committee.

The assistance of, and the messages of our executive secretary, John Hunton, and his entire office personnel as well as that of Ed Clancy, Glenn Gillette and Jerry Pettis and Mr. Ben Read are gratefully acknowledged.

In many county society groups we have found able and conscientious doctors, whom we salute in this report. They are a credit to the profession and are now showing the leadership which we all admire. The effect of their efforts is very apparent in their communities and it is to be hoped that physicians everywhere will continue to exert themselves in the development of their cities and counties. Medical counsel in community affairs is a very desirable activity, and more physicians should identify themselves with clubs, veterans' organizations, city councils, boards of directors of various groups and chambers of commerce.

Blood is still urgently needed. We must keep this need before the public constantly and assist the program by word and deed.

In closing I wish to call attention again to the need of our medical schools for supplementary funds. Have you done your share? Why make it necessary for government to subsidize medical education when gifts are tax free and 100 per cent of the money is turned directly over to the school of your choice? It is difficult to understand the apparent apathy to this worthy project. "Keep Medicine Free in Fifty-three."

Respectfully submitted,

JOHN W. GREEN, *President-Elect*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

The House of Delegates functioned very expeditiously at the Interim Session. The Reference Committees carried out their tasks with a minimum of confusion.

The business of the House is continuing to increase. Much thought is being given to streamlining the agenda. The visual roll call is meeting with universal approval. Committee reports and other routine business are being presented with a minimum expenditure of time.

Full discussion of the important problems coming before the Delegates must be given ample time necessary for proper consideration. This is the primary function of the House of Delegates.

Our next Annual Session will continue to have improvements in planning for the House of Delegates. It is hoped that the meetings will move rapidly but thoughtfully. In this way we may eliminate the late evening endurance contests which are conducive of neither good judgment nor definitive actions.

Respectfully submitted,

DONALD A. CHARNOCK, *Speaker*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

The Speaker in collaboration with the Vice-Speaker has been making all possible efforts to streamline procedures and to shorten the time necessary for roll call, etc.

Respectfully submitted,

WILBUR BAILEY, *Vice-Speaker*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

The Council procedure for the year has been somewhat more flexible than in the past due to an attempt to hear members and other interested persons who, because of one reason or another, were forced to appear during certain hours of the morning or afternoon. Unfortunately, it has not been possible to accommodate everyone as completely as could be wished, but an honest attempt has been made to do so. Barring such shifts in the agenda, the mornings have been devoted to committee reports and business of a routine nature, the lunch periods to hearing representatives of our own and other groups who wished to appear before the Council at that time, and the afternoons to the consideration of new problems.

As in the past, the meetings have been published regularly in CALIFORNIA MEDICINE so that the membership at large has been able to follow Council proceedings quite completely.

The chairman would like to thank the Council membership for their splendid record of attendance, for their interest, and for their willingness to give advice whenever called upon. He would also like to thank Dr. Murray, Mr. Hassard, Ben Read, John Hunton, Ed Clancy, and the other members of the public relations group for their assistance and advice.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman of the Council*

Report of the Council

To the President and the House of Delegates:

The Council has met on 12 days of the past calendar year, having scheduled five days of meetings between sessions of the House of Delegates and seven days during the Annual and Interim sessions of the House. Minutes of all meetings have appeared in CALIFORNIA MEDICINE and in themselves indicate the scope of the Council's activities.

It is the policy of the Council to welcome to its meetings all committee chairmen or members who wish to discuss matters pending before their committees. Likewise, the Council is ever ready to invite other guests to participate in discussions of matters of interest to the Association and its members. The list of invited guests often dwarfs the Council membership.

Listed below are some of the more important items which have come before the Council during the past year.

1. *State Department of Public Health:* Representatives of the State Department of Public Health have been invited to all Council meetings and problems pertaining to that department have been freely discussed. Among the items of mutual interest are laboratory animals and inspection, hospital construction funds, tumor registry, the Crippled Children's Act, rabies control, milk pasteurization and certification and the use of silver nitrate or other agents in the eyes of the newborn. Through its Committee on Public Health and Public Agencies, the Council has maintained a constant and friendly contact with the Department of Public Health, in the interest of sound public health measures and administration.

2. *California Physician's Service:* Each Council meeting is given a report by representatives of California Physicians' Service; at the same time, the Council is represented on the C.P.S. Board of Trustees by Councilors Morrison, Dau and Heron. Thus a complete liaison is accomplished and the two organizations are kept advised of each other's actions and policies.

3. *Disciplinary Actions:* By terms of the By-Laws, the Council may be called upon to name a referee to conduct disciplinary hearings in the county societies. The Council also serves as an appeal body for any county society member who wishes to appeal the findings of a county society in disciplinary proceedings. During the past year the Council has heard one appeal and now has another pending. The Council has also appointed referees to conduct four disciplinary actions. Such proceedings are strictly in line with a democratic procedure and serve as a safeguard to the public and to other members of the profession.

4. *Industrial Fee Schedule:* The Council has been kept advised of the actions of the Committee on Industrial Accident Commission, which is working to achieve a new and compensatory schedule of fees for industrial accident cases. Dr. Francis J. Cox, chairman of that committee, has regularly sought the consent and advice of the Council before taking steps in furtherance of committee policies. It is the Council's hope that progress toward a modern industrial fee schedule may be made in the near future.

5. *Student American Medical Association:* The Council has continued to support the California chapters of the Student American Medical Association. Toward this end it has named Association members to serve as advisors to the various chapters. It has also authorized the issuance of subscriptions to the official journal at a cost to the student of only $1 a year. In addition, it meets the expenses of one representative from each chapter to the annual Student A.M.A. meeting and invites two representatives from each chapter as guests of the Association at the C.M.A. Annual Session. Chapters have now been formed at four of the state's five medical schools and it is hoped that a similar chapter may be organized at Stanford Medical School before too long.

6. *Blood Bank Commission:* Several years ago the Council voted to establish a revolving loan fund of $150,000, from which blood banks sponsored by the county medical societies could borrow, on a matching basis, to meet their capital needs. To date $106,000 has been loaned from this fund to four blood banks. Repayments, made on the basis of a fixed sum per unit of blood drawn, have totaled $39,096 and are continuing to be made monthly by the borrowing banks. A balance of $66,904 remains outstanding on these loans. The Council has been happy to foster the community blood banking movement in California, a program which is unique in the country and which is calculated to make blood available to all Californians in time of need. The program has won nationwide acclaim and has been reported to the public in several articles in national publications. Dr. John R. Upton, chairman of the Blood Bank Commission, is to be commended on his unceasing efforts to develop an ideal blood banking program, and Mrs. Bernice Hemphill, who serves voluntarily as administrative assistant to the commission, is warmly thanked for her outstanding contributions to the success of the California system.

7. *Legal Department:* Mr. Howard Hassard, legal counsel, regularly attends Council meetings and keeps the Council posted on legal matters affecting the public health and the practice of medicine. In the past year the Council has authorized the continuation of court action seeking to define the corporate practice of medicine, an action which is currently before the courts. The Council has also been kept advised on numerous other legal items which have been reported in the minutes.

8. *Public Policy and Legislation:* Dr. Dwight H. Murray, legislative chairman, and Mr. Ben Read, executive secretary of the Public Health League of California, have kept the Council posted on legislative matters and have constantly been cooperative and invaluable for their counsel. As another state legislative session gets under way in 1953, the

Council anticipates numerous consultations on legislation. Meanwhile, the Association may feel every confidence in its legislative committee and representatives.

9. *Public Relations:* The Council has approved the public relations program instituted through the Association offices and looks to this program not only as a forward step in achieving high public esteem but also as a valuable aid to the county medical societies. The Advisory Planning Committee, which passes on the various programs prepared by the department of public relations, has been most helpful in evaluating numerous items prior to their being undertaken on a statewide scale.

10. *Group Disability Insurance:* The Council now has under study a proposal for issuance to Association members of a group disability insurance contract. Details are being worked out and an independent analysis of the program sought before definite action is taken. Such a program, if undertaken, would be as a supplement to programs now in operation, not as a replacement for such programs.

11. *Psychiatric Studies:* The Council was requested to appoint a committee to give an opinion on a report on certain psychiatric studies performed in a state institution. Members of the committee, plus other consultants, provided opinions on the report furnished, and the Association has been warmly thanked for this service by the Joint Legislative Budget Study Committee of the State Legislature. A further study for the same legislative committee is now under way.

12. *Rural Health:* The Council is thoroughly in accord with the projected program of the Committee on Rural Health and is ready to support and implement this activity. Fundamentally, the program calls for a cooperative effort among various groups in or interested in the rural health problem, a move which is destined to provide not only better health standards but better public relations.

13. *Psychology:* The Council has attempted in the past year, without success, to compose the differences of opinion between various groups and organizations seeking standardization and regulation in the field of clinical psychology. This subject has been discussed at length, both in state and national circles, and no answer acceptable to the various groups has yet emerged. Continued attention will be given to this problem.

14. *Veterans' Committee:* The Council has appointed a special committee to meet with veterans' organizations in an effort to secure agreement on health and medical care standards for veterans. It is hoped that these meetings may untangle existing snarls and smooth out misunderstandings in the medical care of veterans entitled to such care.

15. *Conclusion:* This report is designed to cover the principal items considered by the Council during the past calendar year. If additional items arise prior to the 1953 Annual Session, the Council will be pleased to make an additional report thereon.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman*

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE C. M. A.

To the President and the House of Delegates:

The Trustees of the California Medical Association is a non-profit corporation, wholly-owned by the Association and made up of members who are at all times the members of the C.M.A. Council. The corporation's sole purpose is to hold accumulated assets of the Association, which from time to time may be contributed to the corporation by the C.M.A. Council out of surplus funds. The corporation has met during the past year in accordance with its legal requirements and its financial statements are printed elsewhere in this issue as a part of the report of the Treasurer.

Respectfully submitted,

LEWIS A. ALESEN, *President*

REPORT OF THE SECRETARY

To the President and the House of Delegates:

The Secretary was reelected by the Council at its meeting on April 30, 1952.

He has attended the various meetings of the Council and Executive Committee and has edited the minutes that were prepared by the Executive Secretary, with the aid of the Legal Counsel and the Chairman of the Council. In addition, the Secretary presided over the meetings of the Committee on Scientific Work, and at the meetings of the section secretaries in arranging for the 1953 convention. This past Interim Session the secretaries of the sections on Medicine and General Surgery arranged for the scientific speakers. Further, the Secretary attended meetings of the Committee on Postgraduate Activities and other committees appointed by the House and Council.

He has been active on the Cancer Commission and the liaison between this Commission and the Council has been materially strengthened by having a mutual member.

The attention of the membership is called to the minutes of the Council and the Executive Committee that are printed in CALIFORNIA MEDICINE. It is strongly recommended that these be read in detail by all members.

Respectfully submitted,

ALBERT C. DANIELS, *Secretary*

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your executive secretary submits herewith his report for the past year, divided into the various activities falling within the duties assigned to him by the Council.

1. *Administrative:* The Association office is currently undergoing alterations and additions. When this work is completed, the office will be one unit, instead of two as in the past, and will provide some 1,200 additional square feet of floor space. The Executive Committee has approved a five-year lease on this space, which will protect the Association against rent increases and the possibility of losing the cost of the necessary construction. The enlarged office will permit a better arrangement of the business functions of the Association and should provide a more efficient operation throughout.

The staff in the main office now consists of the executive secretary, his assistant, an assistant to the editor, an advertising manager, an associate director of public relations and seven office assistants who serve as secretaries, bookkeepers and assistants to the department heads. In the Southern California office are located the director and associate director of public relations. These men have no full-time secretary but use a secretarial service as needed.

There are also three physicians serving part-time in Association activities. These include the Editor, the director of postgraduate activities and the medical director of the Cancer Commission. The latter two employ part-time secretaries. One additional full-time employee serves the Blood Bank Commission in offices maintained in the San Francisco Medical Society headquarters.

The office equipment is in good condition and modern. New equipment is needed continually to care for the ever-

increasing membership records and expanded activities of the Association. At present there ample filing facilities and sufficient typewriters, adding machines, Mimeograph and Addressograph machines to handle the business of the office efficiently and promptly. Some personnel training will soon be needed to handle the telephone switchboard which has now become a necessity and will soon be installed.

2. *Membership:* In accordance with By-Law requirements, the following account of county society members as of November 1, 1952, is given:

MEMBERSHIP—December 31, 1952

Alameda-Contra Costa	1,033
Butte-Glenn	57
Fresno	228
Humboldt	61
Imperial	42
Inyo-Mono	9
Kern	140
Kings	26
Lassen-Plumas-Modoc	20
Los Angeles	4,755
Madera	17
Marin	90
Mendocino-Lake	35
Merced-Mariposa	40
Monterey	122
Napa	55
Orange	222
Placer-Nevada-Sierra	56
Riverside	124
Sacramento	278
San Benito	9
San Bernardino	251
San Diego	553
San Francisco	1,468
San Joaquin	155
San Luis Obispo	59
San Mateo	285
Santa Barbara	157
Santa Clara	377
Santa Cruz	75
Shasta	29
Siskiyou	15
Solano	65
Sonoma	119
Stanislaus	111
Tehama	11
Tulare	80
Ventura	78
Yolo	35
Yuba-Sutter-Colusa	40
	11,382

The membership count as of November 1 of each year determines the representation of the county societies in the House of Delegates sessions of the following year. The above list, therefore, has been used in computing county society representation for the 1953 sessions. Each society is entitled to one delegate for each fifty active members or major fraction thereof, with a minimum of two delegates for each.

As to the representation of the Association in the House of Delegates of the American Medical Association, the membership now entitles the C.M.A. to twelve A.M.A. delegates. This is an increase of one delegate from 1952 and places the Association definitely in second place in the A.M.A. House. New York leads with 17 delegates, while Pennsylvania is in third position with 11 and Illinois fourth with 10. At the present rate of growth in the Association's membership it is not unlikely that a thirteenth A.M.A. delegate may be added for 1954.

3. *Meetings:* The executive secretary has attended all meetings of the Council and the Executive Committee. He has attended the two A.M.A. meetings, where he serves as secretary to the California delegation. In company with the President or President-Elect he has visited 25 of the county societies in the past five months. Some of the county meetings have included related meetings of the county auxiliaries.

4. *Financial:* The Association completed its fiscal year ended June 30, 1952, with a balance of $52,301 of revenues over expenditures. Total revenues, including those for the Journal, came to $593,855 for the year, compared with a budget of $566,250 and revenues of $569,334 for the preceding fiscal year. Total expenditures for 1951-1952 amounted to $541,554, compared with a budget of $615,260 and the previous year's total of $603,613.

CALIFORNIA MEDICINE showed total revenues for the year of $155,508, including $117,683 in advertising sales. This compares with a total of 147,477, including advertising revenues of $111,673, for the preceding fiscal year. Expenditures amounted to $129,970, leaving a net profit on the Journal of $25,538. For the 1950-1951 fiscal year, Journal expenses were $122,493 and net profit was $24,984.

The Association is in excellent financial condition, as a study of the Report of the Treasurer will show. The corporate holding company closed the 1952 fiscal year with $23,611 in cash and $1,105,000 in U. S. Government securities. There were no other assets for the corporation at the year-end and the only liabilities were in segregated accounts and surplus.

Administrative expenses for 1951-1952 totaled $167,228, an increase of $19,300 over the preceding fiscal year. Principal increases came in annual meeting expenses and in legal costs involved in litigation. Aside from these two items, the balance of administrative expenses were practically the same as in the preceding year. Expenditures for scientific, educational and public relations activities totaled $244,356, a decrease of $88,836 from the preceding year, when $100,000 was appropriated to the American Medical Education Foundation. Public relations expenditures were $20,574 higher than in 1950-1951, totaling $94,236. Conversely, expenditures for public policy and legislation activities were $39,959 lower, at $51,908.

The financial history of the Association for the past decade shows a trend toward greater size and greater activity. Until the end of 1945 the dues and other revenues of the Association were pretty evenly balanced by expenditures and reserve funds were extremely nominal. In 1946 and 1947, when membership dues were advanced, expenditures were held to a lower level than revenues and a sizable surplus was accumulated. From 1948 to date, the annual dues have declined per member but increased in the aggregate. The steadily increasing membership has resulted in dues revenues ample to operate the expanded activity of the Association and still return a net balance at the close of almost every fiscal period. For the foreseeable future, the Association may expect a continuation of this trend. Membership totals increase practically every week. Simultaneously, the Association has taken several progressive steps in the fields of medical economics and public relations, programs which have called for the expenditure of relatively large sums of money. Fortunately, revenues have increased at an even faster pace than expenditures, so that the total reserves have been increased steadily.

The Council has approved a policy of reinvesting interest and other available reserve funds in U. S. Treasury bonds and bills, in multiples of $5,000. This policy has been strictly adhered to, so that all surplus funds are constantly earning interest and growing through compounding.

5. *California Medicine:* The eminently satisfactory financial return of the official Journal for the past fiscal year has been noted above. Since CALIFORNIA MEDICINE was placed on its own advertising feet some six years ago, it has continued to make friends and attract a large volume of advertising. This has made possible a number of improvements in the Journal, typographically and otherwise, without having recourse to general funds for subsidy. The

Journal is not published as a profit venture but it is obvious that profits are preferable to losses and that increased available funds will permit further improvements in the editorial and news sections without disturbing the general financial structure of the Association.

Editorially, CALIFORNIA MEDICINE continues to occupy its high position among state journals. It is widely quoted throughout the country and highly respected in editorial and advertising offices in every state. Its function is to provide the members of the Association and its subscribers with the best available material along scientific, news, organizational and allied lines. It is believed to be doing this today, although the need for constant improvement is never forgotten.

6. *Public Policy and Legislation:* The executive secretary has continued to work with the legislative representatives and committee members whenever called upon. In 1952 the state legislative session was a budget and emergency session only, not requiring much activity on the part of the Association. In the current year the legislative session promises to be one of the busiest in many years and the usual crop of bills must again be reviewed. The Association office is standing by to help out in any manner it may.

7. *Public Relations:* While the executive secretary is not directly in charge of public relations, he is in a position to oversee the operations of that department and to correlate the activities of the Association with those of the public relations team. These activities, as attested by the reactions throughout the county societies, have been productive of much good will. California is looked upon nationally as one of the most progressive state associations in public relations and your executive secretary has been honored by appointment by the Board of Trustees of the American Medical Association to an advisory committee on public relations to the national organization. This appointment has continued for two years and has another year to run; your executive secretary currently serves as chairman of this nine-man committee.

8. *Annual Session:* At this writing, arrangements for the 1953 Annual Session are well along and the meeting promises to be one of the largest and most important in the Association's history. For the first time, a five-day session will be held and this is calculated to permit more time for conducting the business affairs and scientific sessions alike. Technical exhibits will establish a new record high in number and revenues. Again the Association is faced with the difficulty of fitting its meeting into the quarters available, a problem which has existed for several years and which becomes more aggravated each year. The five-day meeting may ameliorate this situation somewhat but the basic problem remains.

9. *Conclusion:* This report would not be complete without a tribute to the officers, Councilors, committee members and other Association members who devote their time so unselfishly to your affairs. The executive secretary sits in the middle of this great activity and can attest from personal observation the tremendous amount of time, energy and talent expended by these many doctors in working for the good of the organization. Without the ready cooperation of these men and women, the work of the Association office would be greatly increased and hampered.

Full credit must also be given to the entire personnel for their willing and efficient services at all times. The Association is fortunate in having a cohesive organization of employees who have served for some years and who can always be relied upon to turn out a good job without prodding. Each takes a real interest in his or her work and performs his own assignments well, as well as assisting others when the need arises. It would be difficult to single out any individual for special mention in this regard; the entire staff must be mentioned. Mr. Howard Hassard, legal counsel, and Mr. Ben Read, executive secretary of the Public Health League of California, neither of them an employee of the Association, also deserve all possible credit for their great contributions to the efficient and effective working of the organization.

Respectfully submitted,

JOHN HUNTON, *Executive Secretary*

REPORT OF THE EDITOR

To the President and the House of Delegates:

By little and little in the last few years CALIFORNIA MEDICINE has developed a style of presentation intended to make it attractive to as many as possible of its potential readers. A principal aim is to present good material in such a way that any practitioner of medicine, whatever the special or general nature of his medical interests, can easily read any article in your Journal—even one on a subject remote from his usual field—without stumbling over the provincial language of specialization.

To this end it is sometimes necessary in manuscript to supply universally understood terms to take the place of patois that, however acceptable in the specialty in which it has particular meaning, is not at all informative to readers in general. And sometimes sentences are recast in the service of clarity, and sometimes—although no great pretensions can be made in this respect—simply to improve the literary quality.

Such changes are made with the reader uppermost in mind. Care is taken not to change the meaning intended by the author; and authors of course have opportunity to review the revisions before publication. Even so, almost any editor must wonder, now and again, just how far his license extends—must wonder whether in discharging his primary duty to readers, he may not do a disservice to authors or seem to treat them less than courteously.

In quest of at least partial answer, letters were sent to the authors of all articles that appeared in four issues of CALIFORNIA MEDICINE, asking for candid opinion as to whether the revisions of their manuscripts were reasonable and helpful or needless or damaging.

On the whole the answers—a surprise to one who occasionally as an author has had moments of less than kindly feelings toward editors—encouraged rather than rebuked. The range was from reproof to wholehearted sanction. Happily, the preponderance of replies was of the latter order. In addition, some of those who answered made valuable suggestions.

Several changes were made during the year to improve the appearance of your Journal. Headings for the various sections have been dressed up, a more arresting type-face is used for titles of articles, the lines of type in text are a little farther apart for ease of reading, and subheads are set in bolder type for accent.

The number of unsolicited manuscripts received for consideration increased considerably in 1952, as is shown in the following table:

	Annual Session		Other		Printed	
	Rec'd	Accepted	Rec'd	Accepted	Rec'd	Accepted
1950.....	179	82	114	66	293	148
1951.....	138	89	79	42	217	131
1952.....	143	101	126	84	269	185

The editor has many persons to thank for valuable help. Robert F. Edwards, the assistant to the editor, has continued to do a superb job of preliminary editing of manuscripts, of arranging the set-up of the Journal and of making innumerable helpful suggestions of all sorts. Mrs. Rooney

of the office staff has kept a close watch over and has maintained great interest in all the activities of the headquarters office. For continuing cause the editor is constantly grateful to members of the Editorial Board, to whom has fallen the task of reviewing and appraising an increasing number of manuscripts. That their work may not go wholly unrecognized by those they serve, it is suggested that all members of this Association read the list of Editorial Board members which is printed on Advertising Page 2. The editor's gratitude goes also to many others who have reviewed books, have given special advice about manuscripts and have prepared material on assignment.

Respectfully submitted,

DWIGHT L. WILBUR, *Editor*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates:

The Legal Department submits the following report covering the interval between the 1952 Annual Session and the time of presentation of this report, February 1953:

During the past year we have attended all meetings of the House of Delegates, Council, and Executive Committee, as well as meetings of the C.P.S. Study Committee, Medical Services Commission, and other committees and agencies of the Association. The number of committees and agencies and the time required in attendance at various meetings increases each year.

We have also prepared and submittted opinions on a variety of subjects, as requested by the Association or its officers or component societies.

In addition to our advisory services, we have also undertaken, at the instance of the Council, the following:

1. Physicians' liability cases:

As amici curiae we appeared in the case of *Pierce vs. Linde*, on the question of whether a physician practicing in another state (Nevada) is legally qualified to act as an expert witness in California. The case was pending before the appellate court at the time of our last report. Since then it has been decided in favor of the ruling of the trial judge that the physician from out of the state was not sufficiently qualified to act as an expert witness in California. The decision, however, did not eliminate entirely the possibility of out-of-state physicians acting as experts in malpractice cases. The court limited its decision to the fact that the particular witness was not acquainted with the standards of orthopedic surgery in the San Francisco Bay area.

2. Unlicensed practice:

Since our last report to the House of Delegates in connection with *Complete Service Bureau et al. vs. San Diego County Medical Society, et al.*, we have filed an appeal from the decision of the trial judge, holding that Complete Service Bureau was not engaged unlawfully in the corporate practice of medicine. Our appeal is now pending before the District Court of Appeal, Fourth Appellate District, and the appellants' opening brief has been prepared, printed and filed. The appeal involves two very important questions of law: First, whether or not a group of physicians practicing in a community have the legal right to apply for an injunction against unlicensed practice by others; and second, if there is a right of action for an injunction, do the activities of Complete Service Bureau and its management constitute corporate practice of medicine, and hence "unlicensed practice."

As to the first question, there are decisions in other states that permit lawyers, physicians, and dentists to enjoin unlicensed practice, on the ground that licensed physicians, attorneys or dentists have a legal right to be protected from invasion of their particular professions by those who are unlicensed. However, it has never been directly decided in California whether or not such a right of action exists here. The California Supreme Court has inferred an affirmative answer, but it has not directly ruled.

The second question of law turns on whether or not a closed panel group can use the term "nonprofit" and thus evade the rule against the corporate practice of medicine. If it is possible so to do, there is then a very serious loophole in the long-established rule of law that corporations and other artificial legal entities may not practice one of the learned professions by hiring physicians, dentists or attorneys to render services for them.

The original complaint filed by Complete Service Bureau, claiming damages and alleging that the San Diego Medical County Society and its members had in some manner violated the anti-trust laws, has not as yet come to trial.

3. Legislation:

The 1953 regular session of the Legislature commenced early in January, and for the first two weeks the legislators introduced bills and then recessed until February 24. Over five thousand bills were introduced, each of which must be carefully read to determine whether or not it affects the medical profession. This, as you can well understand, is a terrific job. To date, approximately three hundred bills have been found to affect the practice of medicine in one way or another. At the present time we are analyzing each of these bills to determine whether to recommend to the Legislative Committee approval or disapproval, and to determine whether amendments are necessary in the interest of the public health.

At the annual session, a more detailed report will be given by the Legislative Committee:

4. District hospitals:

In conjunction with Mr. Glenn Gillette, of the Public Relations Department, we have counseled and advised a number of county medical societies and groups of physicians with respect to the establishment of adequate minimum staff standards in district hospitals, and with respect to both statutory and case law governing the operations of publicly owned hospitals. This subject involves a number of delicate problems, both in the field of law and public relations. The medical profession must understand that if hospitals for the care of the general public, as distinguished from the indigent, are to be built and operated by public agencies, then inevitably the establishment and maintenance of adequate standards for the protection of the health of the public will involve political considerations in addition to the factors of health, education and safety.

5. Industrial fee schedule:

During the year we have worked closely with the Association's Industrial Fee Committee, with Dr. Francis J. Cox as chairman, have attended hearings before the Senate Interim Committee on Workmen's Compensation, as well as conferences with insurance representatives, and have, at the request of the committee, prepared and submitted opinions relating to various phases of industrial medicine.

6. Private pay clinics—fictitious names:

Approximately a year ago the State Board of Medical Examiners and the Department of Public Health and the California Medical Association commenced to study the overlapping effect of the Medical Practice Act and the Clinic Law (originally enacted in 1933). The Medical Practice Act forbids the use of any fictitious name or any name other than his own by any physician in connection with his practice. On the other hand, the Clinic Law permits the establishment and maintenance of private pay clinics with the

use of fictitious names. The Clinic Law also provides that it in no way modifies or changes the Medical Practice Act. Also, the Clinic Law applies to clinics operated by chiropodists or osteopaths or chiropractors, as well as clinics operated by doctors of medicine.

Over the years, a number of private pay clinics have been formed by medical groups. These clinics have obtained licenses from the Department of Public Health and have used fictitious names, thus raising a serious legal question as to whether violations of the Medical Practice Act have occurred. After full consideration of all of the factors, it was felt that it would be most unwise to attempt to undertake a rigid enforcement of the fictitious name sections of the Medical Practice Act, in so far as medical groups operating in good faith under clinic licenses are concerned. On the other hand, it was felt that for the future, the law should be fully clarified, and that the use of the term "clinic" should be restricted, in substance, to charitable, teaching and research institutions. At the same time, it was recognized that group practice of medicine is a lawful method for engaging in private practice, and that physicians in groups should not be required to use awkward lengthy titles, including each and every name. Accordingly, the Clinic Act was redrafted to strengthen its provisions relating to charitable, teaching and research institutions, and to eliminate entirely the private pay clinic for the future (without interfering with those now in existence). The Medical Practice Act fictitious name sections were redrafted to add an express recognition of medical groups, and to incorporate a provision that groups of physicians may use a common name containing the surname of one or more of the partners and the phrase "Medical Group." The revised Clinic Law and revised fictitious name sections of the Medical Practice Act are now pending before the Legislature.

7. County society by-laws:

During the year, we reviewed and submitted opinions to several county medical societies in connection with the by-law revisions.

The foregoing merely outlines briefly a few of the major activities in which we have engaged on behalf of the Association. There are a number of other items that to include would unduly lengthen this report.

Throughout the year we have endeavored to be of service to the Association, its officers and committees, the House of Delegates and the Council, and the various county societies. In addition to the writer of this report, Mr. George A. Smith and Mr. Alan L. Bonnington, in our San Francisco office, and Mr. Louis M. Welsh, of our Los Angeles office, have contributed generously of their time in carrying out the functions of the Legal Department. It has always been a pleasure to be of service.

Respectfully submitted,

PEART, BARATY & HASSARD
By HOWARD HASSARD

REPORT OF THE TREASURER

To the President and the House of Delegates:

The Treasurer was reelected by the Council in May, 1952. The actual duties of this office are nominal, the real handling of monies being performed by the office staff at 450 Sutter Street, San Francisco. All of these employees are bonded, as well as the officers of the Association.

The incoming monies of the accounts are kept in a manner recommended by the auditing firm of John F. Forbes and Company, who also check the presence of cash, securities and other assets, and certify to these.

Submitted herewith is the series of accounts for the fiscal year July 1, 1951 to June 30, 1952. Members are urged to study these accounts for a true picture of the Association's financial situation.

Respectfully submitted,

ALBERT C. DANIELS, *Treasurer*

(Balance sheets and statements of income and expenditures appear on following pages.)

CALIFORNIA MEDICAL ASSOCIATION

Balance Sheet, June 30, 1952

ASSETS

Cash		$ 44,162.83
Accounts Receivable		6,717.42
Loan Receivable—New Mexico Physicians' Service	$ 9,250.00	
Less Reserve	9,250.00	
Remainder		.....
Other Loans Receivable	$89,944.50	
Less Reserve	88,671.50	
Remainder		1,273.00
Investment in U. S. Treasury Bills (at cost)		298,735.00
Cash Surrender Value of Life Insurance Policies		8,649.04
Trust Fund (contra)		4,183.01
Furniture and Fixtures (at nominal value)		1.00
Deferred Charges		3,098.67
Deposits		2,006.60
Total		$368,826.57

LIABILITIES

Accounts Payable		$ 14,918.85
Accrued Expenses:		
American Medical Association—Delegates' and Other Expenses	$ 3,433.19	
Organization Expense	17.02	
Committees' and Sundry	6,705.12	
Pay Roll Taxes	441.20	
Total		10,596.53
Trust Account—Physicians' Benevolence Fund (contra)		4,183.01
Deferred Income—Prepaid Advertising		1,078.53
Surplus, Exhibit A		338,049.65
Total		$368,826.57

EXHIBIT A

Surplus Credits:	
Reduction in Reserve for New Mexico Physicians' Service Loan	$ 1,500.00
Reduction in Reserve for Loans to Blood Banks	17,328.50
Increase in Cash Surrender Value of Life Insurance Policies	3,804.51
Other	425.00
Total	$ 23,058.01
Operating Surplus for Fiscal Year	52,300.98
Total	$ 75,358.99
Surplus Charges:	
Expenses Applicable to a Prior Period	$ 228.61
To Set Up Reserves for Loans Made to Blood Banks During the Period Ended June 30, 1952	36,000.00
Total	$ 36,228.61
Increase in Surplus for the Year	$ 39,130.38
Surplus, July 1, 1951	298,919.27
Surplus, June 30, 1952	$338,049.65

CALIFORNIA MEDICAL ASSOCIATION

INCOME AND EXPENDITURES FOR THE FISCAL YEAR ENDED JUNE 30, 1952

INCOME

	Fiscal Year Ended June 30 1952	1951	Increase Decrease
1. Membership Dues (exclusive of Journal Allocation)	$412,378.91	$395,808.56	$ 16,570.35
2. Annual Session	20,055.00	18,805.00	1,250.00
3. Miscellaneous Income	3,257.63	4,865.41	*1,607.78*
4. Interest Income	2,656.00	2,377.61	278.39
TOTAL REVENUES	$438,347.54	$421,856.58	$ 16,490.96

EXPENDITURES

5. A.M.A. Delegates' Expense	$ 10,481.37	$ 20,302.26	*$ 9,820.89*
6. Annual Session Expense	31,174.35	23,249.89	7,924.46
7. Employees' Annuities	5,173.32	3,608.52	1,564.80
8. Council—Executive Committee Meetings	2,194.95	2,367.59	*172.64*
9. Equipment Expense	3,940.89	2,014.65	1,926.24
10. Legal Department	12,065.15	16,268.10	*4,202.95*
11. Los Angeles Office Expense	1,897.91	2,109.51	*211.60*
12. Miscellaneous Expense	80.25	237.11	*156.86*
13. Office Supplies and Expense	6,076.07	4,598.44	1,477.63
14. Organization Expense	21,780.37	10,394.45	11,385.92
15. Rent	5,686.96	5,630.28	56.68
16. Telephone and Telegraph	2,354.02	1,967.83	386.19
17. Payroll Tax Expense	2,193.21	1,519.86	673.35
18. Pensions	4,260.00	4,260.00	.....
19. Postage	1,067.48	900.12	167.36
20. Salaries:			
(a) Administrative	30,508.40	30,238.62	269.78
(b) Clerical	12,408.40	10,133.48	2,274.92
21. Secretarial Conference	1,145.31	1,117.26	28.05
22. Office Improvements	1,325.51	.....	1,325.51
23. Travel Expenses:			
(a) Officers	351.23	219.10	132.13
(b) Council—Executive Committee	7,605.07	6,040.71	1,564.36
24. Woman's Auxiliary	1,750.00	750.00	1,000.00
25. Student A.M.A.	1,708.05	.....	1,708.05
SCIENTIFIC, EDUCATION AND PUBLIC RELATIONS:			
26. Department of Public Relations	94,236.37	73,661.92	20,574.45
27. Public Policy and Legislation	51,907.80	67,863.31	*15,955.51*
28. Cancer Commission	15,201.50	11,004.07	4,197.43
29. Committees' Expense	48,206.51	27,842.65	20,363.86
30. Los Angeles Special Appropriation	.....	24,003.56	*24,003.56*
31. Postgraduate Committee	15,900.05	12,972.91	2,927.14
32. Contributions to Benevolence Committee	10,935.75	10,562.50	373.25
33. Donations to Medical Libraries	5,467.88	5,281.24	186.64
34. American Medical Education Foundation	.....	100,000.00	*100,000.00*
35. Student Nurse Recruitment	2,500.00	.....	2,500.00
TOTAL EXPENSES	$411,584.13	$481,119.94	*$ 69,535.81*
Surplus or *Loss*	$ 26,763.41	*$ 59,263.36*	$ 86,026.77
CALIFORNIA MEDICINE Surplus	25,537.57	24,984.50	553.07
COMBINED SURPLUS or *Loss*	$ 52,300.98	*$ 34,278.86*	$ 86,579.84

INCOME AND EXPENDITURES FOR THE FISCAL YEAR ENDED JUNE 30, 1952

INCOME

	Fiscal Year Ended June 30 1952	1951	Increase Decrease
1. Advertising Sales	$117,683.06	$111,672.70	$ 6,010.36
2. Subscriptions (Non-Members)	2,609.20	2,452.89	156.31
3. Subscriptions Allocated from Dues	34,660.50	32,943.00	1,717.50
4. Reprint Sales (Net)	554.75	408.90	145.85
TOTAL REVENUES	$155,507.51	$147,477.49	$ 8,030.02

EXPENDITURES

5. Printing	$ 84,623.25	$ 82,492.46	$ 2,130.79
6. Illustrations	1,630.64	1,721.82	*91.18*
7. Advertising Sales Expense	14,667.16	10,779.73	3,887.43
8. Advertising Discounts and Collection Expense	2,114.19	1,974.32	139.87
9. Addressograph Expense	1,703.94	1,816.98	*113.04*
10. Postage and Mailing	4,499.02	4,362.02	137.00
11. Rent	2,744.68	1,956.00	788.68
12. Telephone and Telegraph	1,046.65	1,161.71	*115.06*
13. Salaries	16,795.04	15,480.25	1,314.79
14. Office Supplies and Sundry Expense	145.37	747.70	*602.33*
TOTAL EXPENSES	$129,969.94	$122,492.98	$ 7,476.95
Surplus	$ 25,537.57	$ 24,984.50	$ 553.07

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION
(A California Corporation)

BALANCE SHEET, JUNE 30, 1952

ASSETS

CASH (including Trust Funds)		$ 23,610.89
INVESTMENTS (including Benevolence Fund Investments)		1,105,000.00
TOTAL		$1,128,610.89

LIABILITIES

TRUST ACCOUNTS:			
Benevolence Fund		$ 45,301.43	
Morris Herzstein Bequest Fund		6,141.69	
Total Trust Accounts			$ 51,443.12
ENDOWMENT FUND			276.74
SURPLUS:			
Contributed Surplus		$882,915.99	
Earned Surplus:			
Balance, June 30, 1951	$167,631.44		
Add—Adjustment for Bond Premium Applicable to Bond Purchases During the Fiscal Year Ended June 30, 1951	45.32		
Adjusted Balance, June 30, 1951	$167,676.76		
Net Income for Year, Exhibit B	26,298.28	193,975.04	
Total Surplus			1,076,891.03
TOTAL			$1,128,610.89

EXHIBIT B

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

STATEMENT OF INCOME FOR THE YEAR ENDED JUNE 30, 1952

INCOME—INTEREST ON BONDS		$ 26,369.87
EXPENDITURES:		
Audit Fee	$ 300.00	
Custodian Fee	308.76	
Miscellaneous	115.02	
TOTAL		723.78
REMAINDER		$ 25,646.09
ADD—THE EXCESS OF MATURITY VALUE OF BONDS, PURCHASED DURING THE YEAR, OVER THE COST CHARGED TO THE BOND ACCOUNT, TO REFLECT MATURITY VALUE OF THE BONDS		652.19
TOTAL		$ 26,298.28

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

San Diego County

To the President and the House of Delegates:

During the past year I have attended the meetings of the Council, and the Interim meeting of the House of Delegates, the minutes of which have been duly reported in CALIFORNIA MEDICINE. I have served with great interest on the C.M.A.-C.P.S. Study Committee; the final report of this committee has been made available to the membership.

The San Diego County Medical Society has continued its growth. The Blood Bank, a member of the California State Blood Bank, has shown continued growth and efficiency in supplying the civilian and military needs of the community.

It is my continued desire to correlate the activities of the state association with the county society.

Respectfully submitted,

FRANCIS E. WEST, *Councilor,*
First District

SECOND COUNCILOR DISTRICT

Imperial, Inyo, Mono, Orange, Riverside and San Bernardino Counties

To the President and the House of Delegates:

The visitation of President-elect John Green, Public Relations Director Ed Clancy, and Public Health League Director Ben Read to the Inyo-Mono County Medical Association was well received by the membership. Present at this meeting in addition to the membership were the Medical Auxiliary and the dentists.

President Lewis Alesen and Associate Public Relations Director Jerry Pettis were enthusiastically received by the membership and Auxiliary of Riverside, Orange and San Bernardino counties. Their visitations are not only pleasingly informative to their audiences but stimulate a desired interest in the problems of C.M.A.

The Orange County Medical Association has volunteered its services to examine all the Boy Scouts expected in that area for the National Jamboree in July. Approximately 50,000 Boy Scouts are expected. This public relations gesture and service by Orange County doctors will be appreciated by all the doctors of California.

Riverside and San Bernardino counties have successfully launched a Bi-County Blood Bank in close cooperation with Dr. John Upton. The bank is successful in service and public relations, and in addition is financially sound.

Councilor-at-Large Dr. Arthur Varden and myself are trying through frequent visitations to the societies in our districts to keep our doctors informed of C.M.A. problems and to acquaint ourselves with local problems, so that in turn we may better represent them in the House of Delegates and at the Council.

The Council continues to function effectively under the able leadership of Dr. Sidney J. Shipman.

The published reports and proceedings of the Council are in your possession in CALIFORNIA MEDICINE.

Respectfully submitted,

OMER W. WHEELER, *Councilor,*
Second District

THIRD COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

I have attended all of the meetings but one of the Council during the last year and I wish to state that as far as I can see, the operations of the California Medical Association are in good condition.

Respectfully submitted,

H. CLIFFORD LOOS, *Councilor,*
Third District

FOURTH COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

The changes in the constitution of the California Medical Association and the Los Angeles County Medical Association have had a year's trial and there seems to be a general acceptance by the doctors of the changes made.

There is a wider interest in the districts in the political affairs of medicine.

The new public relations meetings instituted by the California Medical Association have been well attended and political affairs have been better understood. The untiring work of the personnel of the California Medical Association and its officers have been an inspiration to all of us.

Respectfully submitted,

J. PHILIP SAMPSON, *Councilor,*
Fourth District

FIFTH COUNCILOR DISTRICT

San Luis Obispo, Santa Barbara and Ventura Counties

To the President and the House of Delegates:

As Councilor for the Fifth District I have attended all the meetings of the Council of the California Medical Association during the past year. I have attended all of the meetings of the Board of Trustees of the California Physicians' Service since my appointment to the board as a representative of the Council. I appeared before the members of the Senate Interim Committee, of the State of California, which was studying the problem of rehabilitation of the physically handicapped, as a representative of the Council.

I accompanied President Alesen and members of the Public Relations Department on their visits to local societies. It is the general consensus of opinion in this area that these visits are well worth continuing although it places an additional burden on the persons making these visits.

All of the component county societies in this district have started active public relations programs. Initial comments on this phase of our activities have been favorable in most instances.

The Tri-Counties Blood Bank continues to operate successfully. The volume of blood handled has increased to such an extent that it has become necessary to find larger quarters. The present plan is to build a new building. It is to be constructed so that some of the rooms can be rented for office space if the national blood program is halted.

The cooperation of the officers and members of the component societies on problems of mutual interest has been excellent.

Respectfully submitted,

A. A. MORRISON, *Councilor,*
Fifth District

SIXTH COUNCILOR DISTRICT

Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties

To the President and the House of Delegates:

During the past year I have attempted to attend all meetings of the Council, and have tried to visit different societies in the Sixth District. The district is rather large, from Bak-

ersfield to Stockton. I have not been able to attend as many of the county meetings as I would have liked.

All of the counties have taken an active part in the political set-up in the local community and have had very little trouble in the past year.

Respectfully submitted,

NEIL J. DAU, *Councilor, Sixth District*

SEVENTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

The Seventh District has again seen a moderate increase in the number of medical men in the district. Two of the counties are now entitled to additional delegates and alternates to the House of Delegates.

In the field of voluntary health insurance the Seventh District has always maintained a very active interest and this year several members of the Committee on Prepaid Health Care of the C.M.A. are from this district. Santa Clara County has offered to try out a new deductible type of policy for C.P.S. and Santa Clara County has also established one of the local C.P.S. clearing stations for local insurance adjustments.

Building programs for new medical facilities are going ahead in several counties. San Mateo County has just voted bonds for a new county hospital. The district hospital in Millbrae is within a year of completion. The Santa Clara Medical Society has voted to purchase land on which to erect a permanent home for the society.

In a number of counties there has been an increased cooperative spirit between the supervisors, the county health departments and the county medical society. This has led to revision in some instances of ordinances and provisions of county government that have led to better medical conditions in the county.

As industrialization of the Seventh District continues we know that our medical problems are to increase and plans are under way in several counties to study smog control, school programs, medical plans for unions, group practice, housing, drainage, emergency stations and others that come with the increases in population.

Respectfully submitted,

HARTZELL H. RAY, *Councilor, Seventh District*

EIGHTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

The San Francisco Medical Society has had another very active year. The membership continues to grow steadily.

In pursuance of the established policy of helping the patient to better medical care much attention has been given to improving the understanding between physician and patient. A feature of this program has been a study by a committee headed by President-elect Samuel R. Sherman of the needs of groups of organized labor. In part as a result of these studies the society has been investigating the feasibility of preparing a list of fees for guidance of its membership. It has proved to be a very complex problem.

Anticipating the need for better facilities for the membership the society's board of directors has purchased a very attractive site for the development of new headquarters.

President Edmund J. Morrissey, his officers and the new board of directors and our membership in the House of Delegates together with a fine group of committeemen have launched upon a vigorous and active program.

The membership will be assured of continuation of the society's effective voice in California Medical Association affairs.

Respectfully submitted,

M. LAURENCE MONTGOMERY, *Councilor, Eighth District*

NINTH COUNCILOR DISTRICT

Alameda and Costa Costa Counties

To the President and the House of Delegates:

Activity of the Alameda-Contra Costa Medical Association during 1952 included preliminary work and study concerning a new headquarters building to house its offices, blood bank, and Bureau of Medical Economics. An architect was engaged, site studies were made, and plans for the building are now out for bid. It is hoped that the building will be ready for occupancy in mid-1953.

The services of our executive secretary were lent to the C.M.A.-C.P.S. Study Committee which rendered a final report in December to the C.M.A. House of Delegates.

A detailed study was made by the medical association of the need for additional hospital beds in central Contra Costa County, and its results embodied in a report and request for Hill-Burton funds for the Concord Hospital District.

The general activity of the association and its members included continuation of its work in providing "medical care for all, regardless . . ." and continuation and expansion of its broad public service program in Alameda and Contra Costa counties.

Respectfully submitted,

DONALD D. LUM, *Councilor, Ninth District*

TENTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano and Sonoma Counties

To the President and the House of Delegates:

The year 1952 saw no unusual problems that concerned the Councilor of the Tenth District, although quite a bit of time was spent in attention to routine problems, and general social contacts that are part of the functions of a Councilor. As usual these were pleasant obligations, and for the most part, it was possible to take care of them with dispatch.

In the great majority of instances it was possible to go to the various county meetings of my district, to get to know the different members of the county and its officers, and to have the pleasure of introducing the visiting officials from the C.M.A. in their annual tour of the northern part of the state.

At Santa Rosa we were fortunate to be guests at the home of Horace Sharrocks for a hour or so, before the regular Sonoma County Medical Association meeting. Dr. Sharrocks lives in Vacaville, and the early hour was particularly unusual since it coincided with a brisk storm and blacking out of all electricity, so that the cordial atmosphere of a candlelight cafe existed during our brief stay in his lovely home. We proceeded thereupon to Santa Rosa where a thoroughly successful county medical society meeting was had. There were certain preliminary business activities that had to be carried out by the society first, including the voting for the election. Thereupon our visiting delegation of the C.M.A. spoke briefly and ended the program by showing the film put out by the Mechanics Union entitled "Without Fear."

An especially pleasurable function during the year was the meeting in Guerneville at the home of Dr. Makaroff

who had the District Councilor and several officers from local county societies at a function at his home. An outside barbecue was held and what was particularly important, the Sonoma Society had made an effort to invite local newspaper men as well as the different representatives of the legislature. This was a most successful afternoon with the wives being present, and with everyone having a thoroughly cordial meeting. I feel that such incorporation of newspaper men and governing representatives is a most worthwhile policy for every medical group. It preferably should be part of every county activity at least once a year, since the best way to have friends is to meet them, get to know them personally, and let them come to know that the doctors are friendly human beings whose problems are no more obscure or mysterious than any other professional segment of a society, and men who are most anxious to remain on cordial open terms with their fellow citizens.

At the Napa County Society the meeting proper was held at the home of President Dale Barber. As is usual at that time of year and in that area of the Bay, the lovely evening and afternoon permitted the festivities to be held out beneath the large oak tree in his yard where he has barbecue pits and large generous tables. The delegation from the C.M.A. was most cordially welcomed and encountered many old friends. After the dinner we went into Dr. Barber's spacious home where Dr. Green gave a stirring address on medical ethics, the obligation of the medical societies to help subsidize medical education, and the many benefits which could be derived and are derived from such active support of medical education.

The meeting at Vallejo was of course particularly auspicious, since it is the home county, Solano, of President-elect Green. This meeting was attended also by Dr. Dwight Murray, and we had the further pleasure of having attendant at the meeting the wives of the Auxiliary. Particularly stirring testimonials and congratulations were expressed by the visitors and members of the society who were anxious to honor and observe with pleasure the high station that their fellow member, Dr. Green, has attained. He responded by a carefully selected, sobering, and scholarly address on the obligations of a president, the many problems that face him, and the many duties that medical men have in supporting the activities of the C.M.A. and in particular with helping with the foundation for medical education.

I was unable to join the group in their trip up to Eureka for the meeting of the Humboldt County Society; however, it was possible to proceed with the C.M.A. delegation to Ukiah for the meeting of the Mendocino-Lake County Medical Society. That society has the advantage of not being too large, and thus lending an air of direct contact and personal rapport between the visiting delegation from the C.M.A. and the members of that society. Thus a most pleasant evening was had at that society, although unfortunately the program did start rather late, because of the inclement weather, which slowed part of the delegation, so that they were an hour and a half late. At that Ukiah meeting, before the formal meeting, there was a broad discussion of the standard fee schedule which had recently been adopted at the C.M.A. interim meeting. The members were very anxious to formulate their own ideas as regards to a proper fee schedule. Their general sentiment was in favor of a step in this direction, and they only were desirous of having the further steps made with due caution and circumspection.

The last meeting to be held, namely, the Marin County Society, which is the home county of your Councilor, will be in the latter part of February. We look forward to this meeting which has always been most worthwhile and very well received by our members. After that meeting the formal "round robin" visiting activities of your Councilor will be over, but it will then be spring and time to direct attention to the coming Council meeting later on in February, and to the quickly arriving regular session of the C.M.A. It has been a most worthwhile year from my point of view, in that it is my freshman year, and I of necessity have had to learn the ropes, meet new faces, make new acquaintances, and to try to properly represent the problems and attitudes of my district.

Respectfully submitted,

WARREN L. BOSTICK, *Councilor,*
Tenth District

ELEVENTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba Counties

To the President and the House of Delegates:

During 1952 several new hospitals, or additions, were opened in the area comprising the Eleventh Councilor District and in several communities additional hospital beds are in the planning stage. New doctors have continued to locate in the twenty counties comprising this area, and medical facilities are adequate. In three counties cultists made aggressive attempts to obtain hospital staff privileges, and were successful in Amador County where the county board of supervisors opened the county hospital to osteopaths and appointed an osteopath county health officer. To date relatively few men established in practice have entered the armed services, but the calling of doctors in the remaining priorities under the present law and regulations may cause some dislocations, especially in rural areas having few physicians. The program of the Committee on Postgraduate Activities was expanded during the year in a successful attempt to reach more doctors who are away from medical centers, and, considering the amount of money expended, this is possibly one of the most valuable activities of the C.M.A.

Respectfully submitted,

WAYNE POLLOCK, *Councilor,*
Eleventh District

REPORTS OF COUNCILORS-AT-LARGE

The report of Dr. Sidney J. Shipman as Councilor-at-Large is made a part of his report as Chairman of the Council.

To the President and the House of Delegates:

I have attended and participated in all Council meetings since my election and of the several committees assigned.

Respectfully submitted,

H. L. CAREY, *Councilor-at-Large*

To the President and the House of Delegates:

It has been my pleasure to be in regular attendance at the Council meetings for the year 1952.

I feel that your Council has attacked the various problems with great thought and positive action, and that we closed the year 1952 with a good record of achievement.

Respectfully submitted,

BEN FREES, *Councilor-at-Large*

To the President and the House of Delegates:

Since my election to the Council to fill an unexpired term of one year, I have been active in all Council meetings and have deliberated over the various problems which have involved the California Medical Association.

Recently I was appointed chairman of the Insurance Committee of the California Medical Association. My first assignment is to evaluate the various plans for health and accident group insurance. If the Council acts favorably, on what appears to be a suitable plan, eventually there will be group health and accident insurance available to all members of the California Medical Association. Certain questions have arisen regarding malpractice insurance which perhaps will be evaluated in greater detail in the future if necessary.

Respectfully submitted,

ARTHUR A. KIRCHNER, *Councilor-at-Large*

To the President and the House of Delegates:

As Councilor-at-Large I have attended the meetings of the Council of the California Medical Association and have taken part in the discussions and decisions of the Council. I have also carried out committee and other assignments.

In addition, as director of the San Francisco County Medical Society, I have endeavored to correlate state and county organizations.

Respectfully submitted,

IVAN C. HERON, *Councilor-at-Large*

To the President and the House of Delegates:

During the past year I have attended the Council meetings and have visited, along with the C.M.A. officers, county medical societies in Southern California. The reports of the Industrial Accident Fee Committee, the special C.P.S. Study Committee, public relations, and numerous legislative matters have been outstanding among the many important as well as routine items of business to come before the Council. They were all studied, discussed, and acted upon in the best judgment of the Council.

The published reports and proceedings of the Council meetings indicate the large number of vital problems and the serious thought that has been given them and all affairs of the Association by the elected officers and employees.

Respectfully submitted,

ARTHUR E. VARDEN, *Councilor-at-Large*

REPORTS OF COMMITTEES

EXECUTIVE COMMITTEE

To the President and the House of Delegates:

The Executive Committee has held meetings between Council meetings and such special meetings as were necessary.

The increasing number of problems of the California Medical Association has gradually placed more responsibility upon the Executive Committee. In addition to matters that have been referred by the Council, numerous emergencies arise requiring prompt action by the Executive Committee. Routine matters as well have been handled by the Executive Committee in an effort to shorten the crowded agenda of the Council.

All actions are subject to confirmation by the Council and subsequently published in CALIFORNIA MEDICINE.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

To the President and the House of Delegates:

There have been no meetings of the committee during the past year and no communications have reached me as chairman of the committee from the California State Nurses' Association or from any other society or technical group.

Respectfully submitted,

ROBERT A. SCARBOROUGH, *Chairman*

AUDITING COMMITTEE

To the President and the House of Delegates:

The budget for the fiscal year 1952-1953 was presented to the Council at the annual meeting in Los Angeles, in April 1952.

The budget for 1953-1954 is now under preparation and will be presented at the next annual meeting. Expenditure items were reviewed month by month.

An audit by our certified public accounting firm found all records of the California Medical Association in good order.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON HISTORY AND OBITUARIES

To the President and the House of Delegates:

It is fitting that we pause in our busy routine and pay a tribute to our confreres who have passed on to their final reward in 1952. One hundred and thirty-one have been listed in our central office from every section of the state and practically from every field of medicine.

Several were men of outstanding ability and eminently successful; some were relatively unknown, and the great majority had won a place in their respective communities that will be very difficult to fill.

We are proud of the fine record these confreres have made. May we continue to hold our standards high and carry on in the finest traditions of our profession.

Respectfully submitted,

DEWEY R. POWELL, *Chairman*

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

To the President and the House of Delegates:

The Committee on Hospitals, Dispensaries and Clinics, which is an advisory committee, has completed its assignments and presented its reports to the proper authorities.

Respectfully submitted,

JOHN B. HAMILTON, *Chairman*

COMMITTEE ON INDUSTRIAL PRACTICE

To the President and the House of Delegates:

In 1952 there were no meetings of the Committee on Industrial Practice.

Respectfully submitted,

R. M. WALLERIUS, *Chairman*

COMMITTEE ON MEDICAL DEFENSE

To the President and the House of Delegates:

The only matter coming before the Committee on Medical Defense this year has been that which dealt with Lloyds of London exempting alleged malpractice claims where such were the result of intraspinal anesthesia or attempts at intraspinal anesthesia. The matter has been brought before the committee and further action will probably be necessary.

Respectfully submitted,

H. CLIFFORD LOOS, *Chairman*

COMMITTEE ON MEDICAL ECONOMICS

To the President and the House of Delegates:

Since the Dichter Report, entitled "Doctor and Patient," was published and sent to all members of the California Medical Association last year no material has been submitted to our committee.

The committee held no meeting throughout the year and has no report to make at this time.

Respectfully submitted,

L. H. FRASER, *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

To the President and the House of Delegates:

No problems have been referred or forwarded to this committee and there was no unfinished business. The committee has, therefore, not met. The committee stands ready to meet and be of assistance at any time that problems within its field come to the attention of the officers or House of Delegates.

Respectfully submitted,

LEWIS T. BULLOCK, *Chairman*

PHYSICIANS' BENEVOLENCE COMMITTEE

To the President and the House of Delegates:

The Benevolence Committee has continued its regular activities during the past year and has extended aid to physicians in several areas of the state. In addition, it has participated in the benevolences carried on throughout the year by the Physicians' Aid Association of the Los Angeles County Medical Association.

One beneficiary was removed from the committee's list during the year, when he was aided in being placed in a state home where he can receive needed medical attention. Another was provided with temporary assistance during a period of convalescence from a long illness. Another was able to return to a partial practice and to become self-supporting.

The Benevolence Fund started calendar year 1952 with cash of $15,644 and U. S. Treasury bonds of $27,000 par value. During the year it received $11,086 from the Association, at the rate of $1 per active member. Another $3,665 was received as a contribution from the Woman's Auxiliary to the C.M.A., $980 came from interest on securities and $381 was added to assets through discount on bonds purchased. Total receipts were $16,112. Benefits paid out totaled $7,648 and accrued interest on bonds purchased came to $46, making total expenditures for the year of $7,694.

As of December 31, 1952, the Benevolence Fund had $7,061 cash on hand and $44,000 in securities to its credit, for total resources of $51,061, or $8,417 more than at the start of the year.

The chairman wishes to pay tribute to the Los Angeles organization for its constant cooperation and to recognize the prompt and sage counsel of Drs. Elizabeth Mason Hohl and John W. Sherrick, members of the Benevolence Committee. Both members have been constantly alert to the problems confronting the committee and have aided immeasurably in their solution.

Much credit is also due the Woman's Auxiliary to the California Medical Association for its continued support of this program. The Auxiliary chapters have been most diligent in raising funds for benevolent purposes and the members of the Auxiliary, individually and collectively, are due a large vote of thanks.

Attention is also called to the fact that contributions to the Benevolence Fund might well be solicited from people of means who may wish to support this activity through bequests. Surely this is a worthy cause for the consideration of individuals who wish to aid those less fortunate than themselves.

The chairman has long believed that the contribution of the Association to the Benevolence Fund might well be placed at a higher figure than $1 per member per year. A greater contribution would make the work of the committee more effective and the attention of the House of Delegates is respectfully directed to the opportunity for added support of this activity.

Respectfully submitted,

AXCEL E. ANDERSON, *Chairman*

COMMITTEE ON POSTGRADUATE ACTIVITIES

To the President and the House of Delegates:

During the year of 1952 your Postgraduate Activities Committee has continued the program already under way since 1950. During the year, Dr. Edward C. Rosenow, Jr., of Pasadena has acted as chairman of the committee, assisted by Dr. Herbert W. Jenkins of Sacramento, Dr. Lester S. Gale of Bakersfield and Dr. Albert C. Daniels ex officio. Dr. C. A. Broaddus of Stockton has continued to serve as director of Postgraduate Activities.

During the year, the committee has met eight times in business session to plan the various programs for five regional institutes, twelve county speakers and one ten-lecture circuit series for five northern cities, Ukiah, Eureka, Redding, Chico and Marysville.

The five regional medical and surgical institutes have continued to be very successful and still attract much local interest. During the year, one was held for the southern counties at San Bernardino on January 17 and 18 with a total registration of 136.

North Coast counties met at Santa Rosa, February 14 and 15, registration 136; Sacramento Valley counties at Sacramento, April 3 and 4, registration 199; San Joaquin Valley counties at Fresno, October 2 and 3, registration 213; West Coast counties at Santa Barbara, October 23 and 24, registration 84.

All of our programs have been open without fee to interns and residents. Many military personnel have attended as guests.

Your director has assisted in the conduct of the programs for the Stockton Postgraduate Study Club, the Sunday symposium at Visalia in May, and the two-day convention at Brawley in February.

The speakers for the institutes, the county societies, the circuit postgraduate lectures, and the programs for the several local conferences have been furnished mainly by the faculties of the five medical schools through the cooperation of the representative of the postgraduate teaching department of each school. While we have been able to pay a minimum of $50 per lecture, plus the speaker's travel expense, we still feel greatly indebted to the teaching departments of Stanford, University of California, College of Medical Evangelists, University of California at Los Angeles and the University of Southern California. They have given us one hundred per cent cooperation.

The California Academy of General Practice is allowing hour for hour credit for attendance at all of our programs to rank as credit for the number two classification of fifty hours in three years. This makes it possible for many men to earn their more difficult requirements without too much loss of time from their practice.

An innovation this year was the conduct of a ten-weeks circuit postgraduate lecture series. Ten leading members of the faculty of Stanford University School of Medicine constituted the teaching staff. Each one made the circuit of Ukiah, Eureka, Redding, Chico and Marysville, spending an evening in each city to conduct a quiz conference for two or three hours along the lines of his specialty. Almost 150 doctors registered and attended the courses. They were well pleased with the program and want it continued as an annual event.

A conference of representatives from the five regional divisions of the state with the Committee on Postgraduate Activities and from each of the medical schools is held annually in Los Angeles to plan the year's program.

Your committee feels that the program initiated is of wide general interest and should be continued. Therefore your committee requests the House of Delegates that the Council of the California Medical Association be directed to continue the allocation of funds for the support of this committee in making possible postgraduate opportunities for its members.

The California Medical Association may well feel proud of its part in fulfilling a real service to its membership by making this high-caliber postgraduate opportunity available to them.

Respectfully submitted,

EDWARD C. ROSENOW, JR., *Chairman*

See financial report below.

FINANCIAL STATEMENT

Stockton Office Expense:		
Salaries:		
Director	$ 6,000.00	
Secretary	1,925.00	
Rent	600.00	
Telephone	97.55	
Postage	302.11	
Stationery	131.42	
Printing	1,119.47	
Supplies	192.03	
Extra Help	763.85	
	$11,131.43	$11,131.43
Conferences of Committee:		
Travel expense of conference		793.13
Institutes and County Lectures:		
Speakers:		
Honoraria	$3,300.00	
Expenses	1,453.76	
	$4,753.76	
Refreshments (during Institutes)	211.07	
Hotel	469.51	
Meals	978.98	
Transportation	705.45	
Porter Service	92.25	
	$7,211.02	$ 7,211.02
Circuit Lecture Series		5,000.00
Miscellaneous		216.98
	$24,352.56	$24,352.56
Receipts from Institutes and Circuit Series		7,445.00
		$16,907.56
Budget:		
July 1 through December 31, 1951	$ 7,500.00	
Jan. 1 through July 31, 1952	9,250.00	$16,750.00

N. B.—This report includes the expense of the Circuit Series which was added to the program after the budget was made up.

COMMITTEE ON MILITARY AFFAIRS AND CIVIL DEFENSE

To the President and the House of Delegates:

The members appointed to this committee are as follows: Frank F. Schade, M.D., Los Angeles (1952); William L. Bender, M.D., San Francisco (1953); Justin J. Stein, M.D., (Chairman), Los Angeles (1954).

MILITARY AFFAIRS, SOUTHERN CALIFORNIA

The Southern California Advisory Committee has acted as an advisory group under Public Law 779 to the Selective Service System in Southern California and to the Armed Forces. The Southern California geographical area includes the following counties: Los Angeles, Kern, Santa Barbara, Ventura, San Bernardino, Orange, Riverside, San Diego, Imperial, and the combined counties of Inyo, Alpine, and Mono. This committee is composed of the following: John C. Ruddock, M.D. (Chairman); Wilton L. Halverson, M.D., Maurice Smith, D.D.S., Carl E. Wicktor, D.V.M., and Helen D. Halvorsen, R.N.

The great majority of special registrants are centered in the large areas of population such as the cities of San Bernardino, Bakersfield, Santa Barbara, San Diego, Los Angeles, etc.

The PRIORITY I group of physicians as classified by the Selective Service System have all been processed. (Please bear in mind that physicians who held reserve commissions prior to the time of registration were not required to register and therefore are not reflected in the following figures.) As of October 31, 1952, there were 554 living Priority I Special Registrants in Southern California. Of these the following is true:

	Total
I-A—Classified as available (12 have been physically examined, found acceptable and are awaiting induction; 45 are professionally available but have not been physically examined; 2 have had temporary postponements of induction)	59
I-C (Enl.)—Accepted commissions and now on active duty	212
I-C (Ind.)—Actually inducted, now on active duty	2
I-C (Dis.)—Discharged from active service	1
I-D—Commissioned and awaiting active duty orders	89
II-A—Deferred until March 1, 1953, because of essentiality (only 9 are living in Southern California, the remainder being presently employed out of state)	36
III-A—Hardship classifications	4
IV-A—Sole-surviving son	2
IV-F—Found not acceptable for commissioning as medical officers	149

The PRIORITY II group totals 91 living registrants, as follows:

Total Classified Special Registrants—86	
I-A—Classified as available (17 have been physically examined, found acceptable and are awaiting induction; 5 are professionally available but have not been physically examined)	22
I-C (Enl.)—Accepted commissions and now on active duty	11
I-C (Ind.)	0
I-C (Dis.)	0
I-D—Commissioned and awaiting active duty orders	17
II-A—Deferred until April 1953, because of essentiality (six are living in Southern California, the remainder being presently employed out of state)	11
III-A—Hardship classifications	2
IV-A	0
IV-F—Found not acceptable for commissioning as medical officers	23

In the PRIORITY III group, 1,499 physicians are registered in Southern California. As of October 31, 1952, 633 have been classified as follows:

I-A—Classified as available, subject to change. (Only 6 have been physically examined and found acceptable. The remainder have not completed physical examination and the majority have not been reviewed by this committee, to date)	509
I-C (Enl.)—Accepted commissions and now on active duty	4
I-C (Ind.)	0
I-D—Commissioned and awaiting active duty orders	1
II-A—Deferred because of essentiality	35
III-A—Hardship classifications	3
IV-F—Found not acceptable for commissioning as medical officers	26
V-A—Over age of liability (51 years)	55
V-A—Total cancelled	13
V-A—Total deceased	21

Recent graduates who have had no active military service become special registrants in Priority III upon graduation. We recommend that these men be held in a II-A (deferred) classification until completion of their internships, at which time they automatically revert to a I-A classification. If a recent graduate is under 26 years of age, he also has a liability under the basic draft act. If he has been deferred by reason of internship, student classification, etc., on or after June 19, 1951, this dual liability is extended until he is 35 years of age.

Citizens of Canada, and some other countries which do not have special treaty arrangements, who enter this country as aliens on a visa to accept employment such as a residency and who hold an M.D. degree, must register as special registrants within five days of the time of their entry into this country. Such aliens who have not attained their twenty-sixth birthday must also register as regular registrants within six months from the date of entry. After registration and unless otherwise entitled to a deferment, they will be liable for induction into the armed forces on the same basis as citizens of the United States. (Most of them will fall into Priority III as special registrants.)

If a reserve officer desires to resign his commission, and his resignation is accepted by the armed forces, he must register immediately with Selective Service and take his chances of being inducted under the special registration. (Usually his chances for further deferment are nil.)

The Health Resources Advisory Committee periodically sends lists of medical, dental and veterinarian reservists for our opinion on essentiality in civilian practice or availability for military duty. These names are sent from this office to the local county advisory committees for investigation and report. Recommendations are returned to us for review and transmittal to the Health Resources Advisory Committee, Washington, D.C., thence to the service making the inquiry.

The Korean War started about the first of July 1950, and reserve officers who were activated involuntarily soon afterward have, for the most part, returned to civilian life, having been replaced by special registrants from the Selective Service System under Public Law 779. Many Priority I and II physicians have also completed their obligated duty and have been released from active duty. This committee receives from the Department of Defense the lists of doctors who are presently being released from active duty and these names are forwarded to the local medical societies as potential replacements for communities, hospitals, and areas that are critically in need of medical service. A few of the rural communities in this area continue to hold as essential doctors who should be available under the law. It is hoped that these men can be released when the local medical societies can find replacements.

Public Law 799 is due to expire June 30, 1953. It is an amendment to the basic Selective Service Law and concerns physicians, dentists, veterinarians and all other allied professions. Up to the present time only physicians, dentists and veterinarians have been affected. During the period of operation since August 1950, many inequities have been noted in the law and its operation. The law will undoubtedly be extended by action of the new Congress, and certain inequities are now being brought before the Department of Defense and the Selective Service administrators concerning age limits, credit for previous military service, hardships, commissions applied for and given, and various other discrepancies. By July 1953, Priority I and Priority II will no longer be a problem and could be deleted from the law. The law then could be simplified and concern only two groups—those who have had service and those who have not.

The Southern California Advisory Committee to Selective Service and the armed forces continues to operate with the same personnel that was originally appointed. The appointments were made by the National Advisory Committee upon the recommendation of the California Medical Association. Our work has been made pleasant by the wholehearted support that has been given us by the medical associations in the area within our jurisdiction.

This Medical Advisory Committee is unique because in the mechanics which have been set up for it, the medical profession in itself has a voice in determining whether or not a man is essential to the health, welfare and interest of the community in which he practices. This committee does not procure doctors for the service, but it is the only specific agency of government that can officially request deferment under the law. The committee decides only on one factor, namely, essentiality. All other factors such as hardship, dependency, citizenship, physical acceptance, etc., are the sole prerogative of the Selective Service System on standards set up by the Sixth Army (in this state).

Following is the current policy of schedule for release from active duty, as announced by the Department of the Army:

Priority I, II, or III Reserve Medical, Dental and Veterinarian Corps officers serving involuntarily on active duty will be released upon the completion of twenty-four (24) months' service in their current tours of duty, except that those who had one year or more of active duty between 7 December 1941 and 2 September 1945, exclusive of the time spent in ASTP or V-12 (or internships) must be released before the completion of seventeen (17) months' service unless they volunteer to serve a total of twenty-four (24) months or longer. A further exception is that those officers who are returned from overseas with less than ninety (90) days remaining to serve in their current tour of duty will be separated at the time of arrival in the continental United States, regardless of their priority. It is emphasized that this policy applies only to those officers who were involuntarily called to active duty and remain in their involuntary status—i.e., have not voluntarily extended for any period.

Submitted by JOHN C. RUDDOCK, M.D., *Chairman*

MILITARY AFFAIRS, NORTHERN CALIFORNIA

This committee has been requested by the Health Resources Advisory Committee to the office of Defense Mobilization to take an active part in relocating medical, dental and veterinary reserve officers in civilian practice after completion of their period of active duty. Such reservists will be returning in considerable numbers.

The Northern California Advisory Committee undertakes this function with enthusiasm not only in the interest of returning veterans but also of communities and institutions which face a lack of adequate professional manpower because of military demands. We hope to make this office the point of contact between veterans who want to practice in Northern California, and communities and institutions which need their services.

A copy of a letter sent to all returning veterans is herewith enclosed:

NORTHERN CALIFORNIA ADVISORY COMMITTEE
450 Sutter Street, Room 2009, San Francisco 8
Telephone: DOuglas 2-5280

We have received word that your tour of active duty has been, or is about to be completed. Welcome back to civilian life!

Acting as we do to advise the Selective Service System and the Office of Defense Mobilization on the availability of men who are to replace you who leave the service, we are in close touch with vacancies which will occur in civilian practice. Many opportunities for returning veterans already exist in Northern California, and many more will occur. There is an immediate need for house officers, both in urban and rural hospitals as well as in university teaching services, for physicians, dentists and veterinarians in

private practice, general or specialized, in communities ranging in size from small to large, and for public health officers.

It is not only our privilege, but equally our duty, to help you get started again without delay in civilian life, in the interest of communities and hospitals which need your services badly, as well as for your benefit. We are urging such communities and institutions to inform us of such needs. Thus we strive to make this office the means of getting returning veterans into positions you want and which need you.

If you want to take advantage of one of the many opportunities in Northern California, please tell us what type of work and locality you desire, and something of your professional background so that we may help you get located. We are enthusiastic about the possibilities of this service for all concerned, and, in a broad sense, the maintenance of adequate health services for civilians as well as members of the armed forces.

Write us now. We promise action.

Cordially yours,

WILLIAM L. BENDER, *Chairman*

Increasing numbers of returning veterans are indicating their desire to locate in Northern California and are serving as a most important pool of manpower from which to draw replacements for those whose turn it comes to enter active military service. There is evidence already of decreasing shortages of civilian professional personnel. The process of screening Priority III dentists for availability for active duty is about finished and that of physicians is well under way.

The Doctor Draft Law, Number 799, 81st Congress, will expire July 1, 1953. There is much controversy relative to the law, if any, which is to succeed it. By and large it is my considered opinion that the doctor draft is working smoothly and with a minimum of inequity in this area. We have followed the policy from the start, that we of the Advisory Committees are the "friends in court" of the professional men who are required to register under the law. We base our recommendations for or against availability after personal investigations of each case individually by his fellow doctors in the area in which he practices.

Submitted by WILLIAM L. BENDER, *Chairman*

CIVIL DEFENSE

The California Medical Association has been active in civil defense and has at all times demonstrated its readiness to participate in such a program. This association is readily kept abreast of civil defense activities by its representation on the Governor's Citizens' Medical Advisory Committee and by attendance of representatives at the meetings of the California Disaster Council.

During 1952 there was participation in radiological defense, blood bank and blood derivatives, refresher courses, personnel training and organization, etc. One of the main accomplishments during 1952 was in helping plan for adequate medical supplies. The State Civil Defense Organization has purchased more than $4,000,000 in medical supplies and over 60 per cent are actually on hand in California.

During 1953 it is hoped that all civil defense medical supplies will not only be on hand but will be distributed to all the different regions.

Respectfully submitted,

JUSTIN J. STEIN, *Chairman,*
Committee on Military Affairs
and Civil Defense

COMMITTEE ON PUBLIC RELATIONS

To the President and the House of Delegates:

Following the original directive from the House of Delegates, for the past year the Public Relations Department, on a statewide basis, has (1) assisted in establishing and then publicizing the availability of emergency medical care in practically every one of the component societies, has (2) encouraged the making of that care available without regard of ability to pay and has (3) been instrumental in activating and then publicizing the existence of Public Service committees within the various component societies where misunderstandings between physician and patient can be corrected.

That the effects of this program are reaching the public is best attested to by what *others say about us*—not what we claim for ourselves. A letter from Mr. John B. Long, general manager of the California Newspaper Publishers Association, states:

My dear Ed:

Seeing one of your advertisements giving an emergency telephone number to call to get a doctor quickly in the west San Gabriel Valley just reminded me to write and tell you of the excellent reaction I have been receiving from publishers around the state to your program of grass roots public relations.

It is encouraging to note that, to our knowledge, in no county where our program has been activated, has there been a single unfavorable news story on the lack of medical care in case of an emergency.

This record of accomplishment bespeaks the cooperation of the members of the profession.

The actual work of the department should need no itemization in this brief report as it is best known to the officers and members of the individual county societies where we have been privileged to serve.

We do, however, wish to call the profession's attention to the excellent cooperation displayed by the press, radio and TV from one end of the state to the other.

Routinely, the department—on call—has served county societies in all manner of local problems and projects. We stress again that we are "at your service."

Concluding on a personal note the undersigned would like to commend the loyalty, initiative and intelligent understanding of the objectives of the profession by Glenn W. Gillette, San Francisco, and Jerry Pettis, Los Angeles. These two associate directors are responsible for much of the success of the public relations program during the times when the undersigned is attending the lengthy sessions of the California Legislature.

With the permission of the President and the members of the House of Delegates we would like to present a detailed report during the 1953 meeting of the Association.

Respectfully submitted,

ED CLANCY, *Director*

COMMITTEE ON SCIENTIFIC WORK

To the President and the House of Delegates:

The Committee on Scientific Work as usual held two meetings during the past year and met with the section officers each time.

After obtaining permission from the Council the annual session was lengthened one day so that the House of Delegates could meet on Sunday, May 24, without interference with the Scientific Session. The House of Delegates will meet again on the 27th, during which time no scientific programs are planned, but social or other recreational activities will be carried out.

This year the President's guest will address an evening meeting open to the public instead of the usual general meeting of the Association.

The committee on local arrangements was most valuable during the recent sessions and it is again active this year. With the one free day available between scientific sessions the Committee on Scientific Work felt that ancillary organizations could use this time for meetings without interference with the Annual Session.

The usual press coverage will be carried out under the direction of Mr. Robert Edwards who has done such an outstanding piece of work each year. A "Meet the Press" luncheon will be held on Saturday, May 23, at which time any and all newspaper men are given an opportunity to review all papers, and summaries of papers.

As in previous years, the section executives have been most important in seeing that the meetings run smoothly. They are ably assisted by Mr. Robert L. Thomas, who has done most excellent work in arranging the mechanics of the meetings. Again Mrs. Barbara Rooney has provided the invaluable help of organizing the program and steering the various sections through the difficulties arising with the Annual Session.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*

ANNUAL REPORT OF THE CANCER COMMISSION

To the President and the House of Delegates:

The most important development in the program of the Cancer Commission during the past year has been a distinct acceleration of the Commission's interest in proposed treatments for cancer. While the Commission has always maintained a continuing interest in this subject, the first intensive investigation of a proposed form of treatment for cancer was carried on during the year 1951 to 1952 under the chairmanship of Robert A. Scarborough. The agent under survey at that time was the enzymatic substance designated as arginase, and the principal phase of the Commission's investigation of this proposed treatment of cancer was in the nature of a review of patients who had been treated with arginase. No satisfactory evidence of effectiveness could be demonstrated for this drug, and at the time of the 1952 annual meeting of the California Medical Association, a series of newspaper articles describing this investigation and emphasizing the failure of arginase to accomplish any objective benefit in cancer was picked up widely throughout the state.

During the ensuing months of 1952, claims which were and are being made for several unrecognized forms of treatment became an issue of increasing importance. The officers of the Commission were consulted by a number of press services and national magazines during the summer and fall of 1952 concerning efforts being made to obtain publicity for an agent referred to as Laetrile, sponsored by the Krebs group of San Francisco operating as the John Beard Foundation. Since September 1952 a thorough investigation of Laetrile has been done from laboratory, experimental and clinical angles, resulting in the preparation of a report for submission to the Council, demonstrating again the lack of any evidence of effectiveness of this widely touted agent.

The increased interest and discussion of this and other alleged treatments for cancer has, as you know, commanded the interest of the Council. The Cancer Commission is deeply grateful for the interest and support offered by the President and the Council, as a result of which the Commission is undertaking still further expansion of this phase of its activities.

Early in January a joint statement by the President and the writer concerning the intent of the California Medical Association and its Cancer Commission vigorously to pursue such investigations in the interest of the people of California was released to the press. This announcement secured widespread publicity and very favorable comment. Several weeks later the Secretary of the Commission sent to editors of all California newspapers, for their information, a statement from the Cancer Commission concerning our intent to pursue objective and honest studies of proposed treatments for cancer, and emphasizing our belief that such announcements as will be made concerning specific forms of proposed treatment should be of interest not only to the medical profession, but to the public as well.

The report on the Commission's investigation of laetrile, referred to above, is scheduled for early publication in CALIFORNIA MEDICINE, as well as for release to the press in a synoptic form.

Other forms of alleged treatment for cancer enjoying some degree of popularity in California are scheduled for an investigation during the coming year. In this connection the Commission has designed a format which will be followed in all such investigations.

Other continuing activities of the Cancer Commission during the past year may be summarized as follows:

1. In the 1952 calendar year 21 county medical societies were provided with Cancer Conferences. A Conference was provided for the Fourth District Dental Society of Los Angeles. Total attendance at all conferences was 1,440, of a membership of 4,188 (34.4 per cent). The total cost of all conferences was $2,000 to the Cancer Commission and $777.92 to the California Division of the American Cancer Society. Twenty-four county medical societies will be offered Cancer Conferences in 1953.

2. Sixty Consultative Tumor Boards were given Cancer Commission approval. Inspection of these Boards indicated that they were operating in accordance with the minimum standard requirements of the Commission. It is increasingly apparent that the services of these Boards are being sought by physicians. Eight new Boards have organized recently.

3. The Mid-Winter Conference on Tumor Pathology was held under the auspices of the Cancer Commission at the Fairmont Hotel in December as a joint session with the Southwestern Region of the College of American Pathologists and the California Society of Pathologists. Henry D. Moon, M.D., was chairman, James F. Rinehart, M.D., was moderator and the program chairman was George J. Hummer, M.D. The customary large attendance of pathologists characterized this session.

4. The annual Pre-Convention Tumor Pathology and Radiology Conference will be held in May, 1953.

5. As announced in the Commission's report for last year, the Cancer Commission now has under its auspices the Tumor Tissue Registry located at the Los Angeles County Hospital, as a state-wide activity. The financial support of this project is now being provided jointly by the California Medical Association and the California Division of the American Cancer Society. In addition to the consulting group of pathologists at this central Tumor Tissue Registry, there is a corresponding group of pathologists for the San Francisco-Oakland area. Both consulting groups review monthly problems in histopathology submitted by pathologists of the state as well as some material from adjoining states. Currently James A. Kahler, M.D., is chairman of the Tumor Tissue Registry. In addition to consulting service, the Registry is rapidly accumulating a large volume of representative cases now constituting a study collection of microscopic sections, with clinical information and roentgenographic and laboratory data. This collection will perform a service of constantly increasing value to pathologists, and indirectly to physicians generally as well as to the cancer patient in the years to come.

6. The Commission and the California Division of the American Cancer Society continues to provide men in general practice throughout the state with subscriptions to *CA: A Bulletin of Cancer Progress*. Last year nearly 5,000

subscriptions were so provided and the Division supplied over 15,000 copies of the seventh in a series of monographs on cancer, dealing with malignant lymphomas and leukemias.

7. Cooperative effort with the American Cancer Society continues to provide showings of professional films on cancer to medical groups. Outstanding items are films dealing with the problem of early diagnosis in breast cancer, gastrointestinal cancer, uterine cancer and a new film which is available on exfoliative cytology in the diagnosis of gastric cancer.

8. The film on "Breast Self-Examination" has had increased showings to lay audiences during the past year and by actual count 91,701 women have viewed this film.

9. Programs of individual counties in determining the effectiveness of cancer detection in the physician's office are underway, particularly a project conducted by the Riverside County Society, now in its eighth month of operation. The first few months of this project were more or less exploratory, but beginning in September 1952 the program gained momentum, not only in the number of physicians participating and reporting, but also in an increased number of patients seeking cancer detection examinations.

John S. O'Toole, M.D., chairman of the Cancer Committee for the Riverside County Medical Society, reports that the incidence of cancer discovery is higher than that reported by previous similar surveys. The significance of this finding will not be apparent until the plan has been in operation for a longer time, but at present the above observations seem to be valid.

10. The Commission has continued to foster and extend programs of cancer detection as developed on the initiative of individual county medical societies. Correspondence and some considerable personal contact with cancer committees of county medical societies and secretaries of county societies has resulted in a number of satisfactory programs having been instituted during the year. The Commission encourages the polling of the membership of a county medical society to determine those physicians who are interested in and willing to undertake adequate cancer detection procedures. Where approval of the county medical society is forthcoming, the Commission believes that the roster of physicians so set up may properly be available to the county branch of the American Cancer Society and its information center for orderly release of names to those who seek cancer detection procedures. In some instances, of course, the county society prefers to reserve this prerogative for itself. A brief outline on cancer detection, amounting to a statement by the Commission as to methods and potential value of cancer detection, has been prepared and will be released in the immediate future. The Commission recognizes the continuing demand by a part of the population for cancer detection procedures, and the necessity for provision of such service as a part of general health surveys by individual physicians. The Commission sees no reason to consider any change in its established policy that such screening procedures are best done by interested physicians in their offices rather than in Cancer Detection Centers.

The Commission again acknowledges with sincere appreciation the great assistance, financial and otherwise, rendered by the California Division of the American Cancer Society. The Commission also acknowledges the cooperative and helpful liaison which exists with the Bureau of Chronic Diseases of the State Department of Public Health. Dr. Franklyn C. Hill, medical director of the Cancer Commission, continues to render conscientious and highly efficient services.

Respectfully submitted,

IAN MACDONALD, *Chairman*

EDITORIAL BOARD

To the President and the House of Delegates:

With the approval of the Council two members were added to the Editorial Board in 1952—Dr. James E. Reeves of San Diego and Dr. John G. Walsh of Sacramento. Themselves in general practice, they are to review and advise upon manuscripts and other editorial matters having to do with the general practice of medicine. Neither the Editorial Board nor the Executive Committee of the Board met as a unit during the year. The members of the board are:

Chairman of the Board:
Dwight L. Wilbur, San Francisco

Executive Committee:
Albert J. Scholl, Los Angeles
H. J. Templeton, Oakland
Edgar Wayburn, San Francisco
Dwight L. Wilbur, San Francisco

Allergy:
Frank J. Crandall, Jr., Los Angeles
Samuel H. Hurwitz, San Francisco

Anesthesiology:
William B. Neff, Redwood City
Charles F. McCuskey, Los Angeles

Dermatology and Syphilology:
Paul Foster, Los Angeles
H. J. Templeton, Oakland

Ear, Nose and Throat:
Lawrence K. Gundrum, Los Angeles
Lewis Morrison, San Francisco

Eye:
Frederick C. Cordes, San Francisco
A. R. Robbins, Los Angeles

General Medicine:
Maurice Sokolow, San Francisco
O. C. Railsback, Woodland
Edgar Wayburn, San Francisco
John Martin Askey, Los Angeles
W. E. Macpherson, Los Angeles

General Practice:
James E. Reeves, San Diego
John G. Walsh, Sacramento

General Surgery:
Frederick L. Reichert, San Francisco
C. J. Baumgartner, Beverly Hills

Orthopedic Surgery:
Frederick C. Bost, San Francisco
Hugh Jones, Los Angeles

Thoracic Surgery:
John C. Jones, Los Angeles
H. Brodie Stephens, San Francisco

Industrial Medicine and Surgery:
Rutherford T. Johnstone, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, Los Angeles
Donald G. Tollefson, Los Angeles

Pediatrics:
E. Earl Moody, Los Angeles
William G. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena
Alvin J. Cox, San Francisco

Psychiatry and Neurology:
Karl M. Bowman, San Francisco
John B. Doyle, Los Angeles

Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles

Urology:
Lyle Craig, Pasadena
Albert J. Scholl, Los Angeles

Pharmacology:
Hamilton H. Anderson, San Francisco
Clinton H. Thienes, Los Angeles

Public Health:
George Uhl, Los Angeles
Charles E. Smith, San Francisco

Respectfully submitted,

DWIGHT L. WILBUR, M.D., *Chairman*

ADVISORY PLANNING COMMITTEE

To the President and the House of Delegates:

The Advisory Planning Committee has met regularly during the past year, holding its meetings on the day before each meeting of the C.M.A. Council. Its recommendations to the Council have been reported as a part of the Council minutes.

During the past year the committee has gained two new members and lost two former members. Mr. Boyd Thompson, executive secretary of the San Joaquin County Medical Society, and Mrs. Jane Algeo Watson, executive secretary of the Sacramento Society for Medical Improvement, were appointed members of the committee by the Council. Mr. Frank Kihm of San Francisco County and Mr. Vance Venables of Kern County, both resigned from their positions, have dropped from the committee's membership.

The committee's activities in recent months have been directed almost entirely to matters of public relations. In this connection, it is the chairman's firm conviction that the committee serves an extremely valuable function in acting as a sounding board on such matters. It is obvious that any statewide public relations activity must have the thorough support of the county society executives if it is to succeed. The Advisory Planning Committee acts as a testing ground and, at the same time, as a critical board on all public relations proposals. In these capacities alone, if for no other reasons, the committee's existence appears to be a sound function for the Association.

Respectfully submitted,

JOHN HUNTON, *Chairman*

C. M. A. BLOOD BANK COMMISSION

To the President and the House of Delegates:

This report must of necessity be summarized because of space requirements. Each activity or notation listed is backed by voluminous reports kept on file in our central Clearing House office. Copies of the more important phases of work in the last year were sent to the C.M.A. head office, and I have sincerely tried to keep you fully informed on all blood bank matters by reporting them before the Council meetings.

During the year we lost a most valued member of our Blood Bank Commission. With your permission, sirs, I should like to dedicate this report to the memory of Dudley Saeltzer of Sacramento. A great deal of his heart, work, influence, and loyalty are contained in the summarization.

Activities:

1. Blood drawn by our system banks for the armed services since the Korean War through December 1952 totaled 388,019 units.

Blood drawn, processed, and distributed by our system banks for the day by day civilian requirements during 1952 totaled 119,149 units.

Each unit of blood drawn for civilian and military needs was procured, processed, and distributed *at cost.*

2. It has been a year of intensive integration and consolidation within our blood banking system of eleven banks.

3. Expansion of interstate reciprocity and further development looking toward a national non-profit system has occurred. Extreme interest has been shown in our plan of action by numerous state medical societies. Organized medicine throughout the country is taking a more active interest in shouldering its inherent responsibility; it is a good sign for the future.

4. Work continues on a general remodeling of existing blood banks and expansion of the physical plants to meet the population growth requirements within our state.

5. Standardization of administrative and technical procedures progresses apace in order to develop a complete and uniform state blood banking operation.

6. Technical and administrative assistance was offered to other states and a few foreign countries in order to aid them in establishing blood banks in conformity with our non-profit community network.

7. There has been a widespread dissemination of pertinent information to the general public through the media of radio, television and lectures. We logged over 15,000 miles of travel, most of this by air.

8. Honest attempts have been made to improve working relationships between our system banks and the Red Cross. Too many problems still develop and they tend to obscure our common goal. Twelve years of experience only serves to confirm our opinion that in peace and disaster our type of blood bank is the most stable. Our system *has* to function and give service in days of depression, inflation, and during a stable economic era.

9. Research on blood, blood derivatives, and blood banking procedures presents a constant daily challenge, our progress is slow but sure.

10. We had six showings of our new exhibits before scientific meetings, with three of these outside the state.

11. Suggestions and proposals were made to the Office of Defense Mobilization. "We recommend the creation of a national blood committee composed of not just two or three organizations, but all agencies interested in blood banking, namely, the American Medical Association and its related specialty societies, the American National Red Cross, the American Association of Blood Banks, the American Hospital Association, the National Institutes of Health, National Research Council, and appropriate defense agencies. This representative over-all committee should be invested with administrative and operational powers and should be the coordinating committee for a national blood program. This commission should be attached to the Office of Defense Mobilization. Similar committees should function at state and local levels." This is not a new idea; we have presented it several times before but to no avail. At this time of writing there is no impartial national blood bank committee to consider and settle interorganizational problems, to impartially consider suggestions, decisions, and the problems of the large number of independent blood banks actively engaged in the national blood program. Our plan, which is quoted above, would go far to cool rising tempers, to make for less friction, and to bring medicine, through the office of the A.M.A., into this vital blood banking program.

12. Realignment of the present state territorial boundaries for our existing blood banks progresses in order to equalize procurement and distribution pressures and inadequacies.

13. Enlargement of our central clearing house duties continues. During December 114 letters were answered. This constantly growing correspondence is mostly made up of out-of-state queries on blood banking.

14. Our California system continues its active participation in the State of California Civil Defense program. Your committee maintains excellent working arrangements with all Civil Defense committees.

15. A careful study was made of the December proposal by the American National Red Cross to make gamma globulin available to areas threatened with polio epidemics. This is our formulated plan: (1) To cooperate with the Red Cross in the gamma globulin program. (2) Our blood banks do not want to be the distributing agency; there are too many dangerous implications. (3) We will inform all blood

donors presenting themselves to our system banks of our role in the program, stressing the fact that we have nothing to do with the distribution of the gamma globulin. (4) We will ask the editor of the C.M.A. Journal and all editors of local medical society bulletins to publicize the known facts on gamma globulin and polio.

Suggestions for 1953. We ask each member of the C.M.A. to be a blood bank ambassador. We particularly ask each member not to immediately place the blame of a reaction or hepatitis on a blood or plasma transfusion. Such unfortunate incidents can be, and often are, due to other causes. Malpractice suits are costly in time and money. They hurt medicine, and they may hurt you, the doctor. Think of the possible implications before making ill-advised statements to lay people. Make it a point to know your local blood bank. Better still, pay it a visit as a donor and see how smoothly it functions—for you. Our "life line" has grown strong because of your support. Our goal is to improve the service to you and to your patients.

Will all who have helped us please accept my grateful and sincere thanks. Each year the list of our benefactors grows longer; may it continue to grow. The wholehearted support of the President, the Executive Council, and the House of Delegates has made my task almost enjoyable. Words fail to express my admiration for our constantly enlarging blood bank family—it is an honor and a privilege to work with them and for them; this report is in truth a compilation of their accomplishments.

And now—let us see what we can do in 1953!

Respectfully submitted,

JOHN R. UPTON, *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

To the President and the House of Delegates:

Your committee recommended in its 1952 report the adoption of the following:

"*Nursing Services in Industry: A Statement of Principle*

"The California Medical Association recognizes the important contribution to industrial health by the members of the nursing profession through the individual activities of the nurses employed by and in industry. Through their contact with individual employees, and with members of managements, they have furthered public health education, the use of community resources, improved personal and plant hygiene, healthier psychological relationships between management and workers, and a closer liaison between the plant employee and the practicing physician.

"It is also recognized, however, that demands are made upon nurses in industry by both employees and management to engage in activities which encroach upon the practice of medicine as defined by the Medical Practice Act and which, if acceded to, cause her services to replace rather than supplement the medical care by physicians which is demanded by the welfare of the patient, as well as being mandatory under the law.

"It is urged that the nurse in industry, having met the emergency with which she is confronted, protect herself, her patient and her employer by referring the patient to a physician for diagnosis or medical care when either is required, and that further treatment be carried on only under such medical supervision. Employers of nurses are urged to facilitate such referrals and encourage them, in order that they themselves may be protected against being involved in violations of the Medical Practice Act.

"Technicalities of the Medical Practice Act are difficult to translate into lay language and no simple definition can be given as to what services may be rendered with impunity. It certainly may be said, however, that any injury serious enough to cause temporary disability or which requires more than protective dressing, or does not respond favorably to procedures described in standard texts on first aid, will require medical treatment. It must be borne in mind that, regardless of the desires of the patient or his personal needs, or the demands of the employer in regard to industrial injuries, a nurse is forbidden by law to either diagnose or treat medical conditions or surgical injuries. It is only as this fact is grasped fully by employees and employers alike that the pressure upon the nurse to exceed her area of function will be lessened.

"Every nurse should be aware of the Medical Practice Act and its implications and understand that to ignore the act and its limitations is to invite inevitable violations.

"The California Medical Association anticipates and welcomes the further extension of employment of nurses in industry in view of their tremendous contributions both to the over-all health welfare, and to the physical and emotional comfort of employed individuals. It looks forward to cooperating fully with the California State Nurses' Association, and the other organized nurses' groups in establishing and maintaining the area in which the professional industrial nurse may function effectively, efficiently, ethically and legally."

The Council, in its September meeting, 1952, endorsed the recommendation of the committee. It was the feeling of your committee, however, that before the statement is formally issued it should be presented to the California State Nurses' Association in order that they might have an opportunity to study it and express their opinions on how the interests of their membership, particularly the industrial nurses, would be affected by this statement. Since their committees have not completed their study a reply has not yet been received. Should it be received before the annual meeting in May, your committee will file a supplemental report.

Should the statement meet with the full approval of the California State Nurses' Association, we contemplate the possibility of its being issued as a joint statement of the California Medical Association and the California State Nurses' Association. It is possible that circumstances will be such as to make it advisable to issue it as a statement of the California Medical Association which has met with the approval of the California State Nurses' Association. It may be that the California State Nurses' Association may suggest changes in the text which would be quite compatible with the aims of the California Medical Association.

Should study by the California State Nurses' Association reveal an inability to endorse the statement in its present form, or with minor modifications, it would seem highly desirable that conferences be held with them with a view toward reaching agreement regarding a statement which would be considered mutually advantageous by both the medical profession and the nursing profession.

Your committee is not inclined to believe that any statement unilaterally or jointly issued at the present time will not require future modification, as conditions in the field change or as changes in the laws or the interpretation of the laws applying to medical or nursing practice take place. It may ultimately be that changes in the California situation or changes in the national statement of "Essentials of Medical Services in Industry" will obviate the present feeling of your committee that the situation in California demands a statement referring solely to the California problem.

Your committee has spent several years reaching the recommendations in the above report. The problem is no less intricate from the point of view of the nurses and their organization and we feel that the time required by them to study the situation is not unduly long, nor do we necessarily expect them to have reached an understanding with us at an early date.

We anticipate that the presentation of the "Nursing Services in Industry: A Statement of Principle" will prove to be of service in inviting further joint exploration by the California Medical Association and the California State Nurses' Association and other organized nurses' groups in the continuing problem of the activity of nurses in relation to the Medical Practice Act.

Respectfully submitted,

CHRISTOPHER LEGGO, *Chairman*

COMMITTEE ON RURAL MEDICAL SERVICE

To the President and the House of Delegates:

Considerable expansion in the activities of this committee has been witnessed during 1952-53. Using the A.M.A.'s policies and techniques as a pattern, the committee undertook to broaden its interests in all fields pertaining to health and medical services in rural areas. Problems peculiar to the state of California, of course, received priority in the committee's deliberations and activities.

Shortly after the beginning of the year, the committee embarked upon a program to develop a Rural Health Council within the state. Working with the director of the Agricultural Extension Service, the State Department of Public Health, the California Farm Bureau Federation and the Parent-Teachers Association, groundwork was laid for the formation of a statewide council. This committee with the aforementioned groups, formed the nucleus about which it is planned other organizations will be drawn in at a later date. The Rural Health Council is now an entity and, although it suffered a recent loss of its chairman, namely Dr. J. Earl Coke, through his appointment as Assistant Secretary of Agriculture, we feel fortunate to have had Dr. Coke as chairman of the Council for the past year and are pleased that he has attained greater recognition which he so justly deserves. The purpose of the Council is to serve in an advisory capacity to similar groups in local areas where problems affecting health in a general or specific way may be resolved by the combined efforts of all interested. Thus it is hoped that there will be little need for the myriad of health councils, committees, conferences, etc., wherein there is little or no medical influence which, in the past, has permitted many misrepresentations and misunderstandings.

Besides taking an active part in the formation of the State Health Council, the committee has continued its interests in problems affecting health and medical service in the migrant areas. In the San Joaquin Valley in particular physicians have fulfilled the needs of medical service to the migrants through an arrangement with the medical society, the Health Department and the growers. The migrant worker has benefited greatly from this demonstration and, although physicians will continue to render service where needed, it is to be noted that the migrant worker is becoming less and less migrant, gaining more and more independence and stability and should, in the not too distant future, become self-reliant and assume his responsibility as do all other citizens. We are pleased to report that our experiences in California have been of assistance to those in Michigan faced with a similar problem.

Committee members have been active in other state and local problems and at the present time are undertaking a study to determine the need for better physician distribution in California. No factual information is available to support or deny the oft repeated charge that there is a lack of adequate physician coverage in many rural areas. Our committee is attempting to obtain the facts concerning this and will report at a later date.

Working with the State Department of Public Health and representatives from various boards of supervisors, the committee is attempting to assist in the solution of the present problem of providing adequate health facilities for certain "playground" areas. Public Health personnel are sorely disturbed at the lack of facilities in many of these areas and it is our sincere desire to be of assistance in this connection. The committee has had several meetings throughout the year with representatives of various groups and benefited particularly by the visit of Mr. Aubrey Gates, field representative for the Council on Rural Health of the A.M.A.

The chairman addressed the California Farm Bureau Federation at its meeting in November and has accepted an appointment by the Governor to his Advisory Committee on Youth and Children.

Future plans include a continuation and an extension of the activities of the State Rural Health Council as well as an activation of Rural Health Committees within the structure of each local medical society. We of the committee feel that health is everybody's business including the physician's and that all matters pertaining to health within the community should have physician representation.

The committee is extremely grateful to members of the administrative staff and the Public Relations Department whose assistance has made the work easier and more pleasant. Without their splendid cooperation and assistance progress would have been extremely slow if at all possible. To other C.M.A. committees and officers with whom the work of this committee has been so intimately entwined we wish to express our sincere thanks.

The Eighth National Health Conference of the A.M.A. to be held in Roanoke, Va., in February will be covered by representation from this committee.

Respectfully submitted,

H. A. RANDEL, *Chairman*

MEDICAL SERVICES COMMISSION

To the President and the House of Delegates:

The Medical Services Commission has held meetings with representatives of the insurance industry and California Physicians' Service since our report to this House of Delegates at the Interim Session, December 1952. The Executive Committee has held two meetings also.

In December 1952 the House of Delegates passed a resolution calling for the commission to undertake a study of all possible legislation that might define and guarantee high standards of medical service in all prepaid plans. We have all phases of this resolution under consideration at this time.

The Council has placed the commission on notice that it will be responsible for any continuation of the work done by the C.M.A.-C.P.S. Study Committee and the C.P.S. Fee Schedule Committee.

The Medical Services Commission is continuing with its efforts to formulate a set of principles under which prepaid medical care plans should be presented to the public.

The commission is proceeding with the collection and codification of data on all types of prepaid medical care.

Respectfully submitted,

LESLIE B. MAGOON, *Chairman*

C. M. A.–C. P. S. LIAISON COMMITTEE

To the President and the House of Delegates:

No meetings of this committee have been held during the past year since no items of business have been referred to it.

Following the thoroughgoing study of C.P.S. relationships by the special committee under the chairmanship of Dr. Wilbur Bailey, its comprehensive report of that study to the House of Delegates, and the action of the House of Delegates upon that report, the original objectives of the C.M.A.-C.P.S. Liaison Committee have been met since the House of Delegates of the C.M.A. has now become the House of Delegates of C.P.S. In addition, the new Medical Services Commission appointed by order of the House of Delegates will make extensive studies into all phases of the prepayment of the costs of illness.

Therefore, it is recommended that the C.M.A.-C.P.S. Liaison Committee be dissolved.

Respectfully submitted,

L. A. ALESEN, *Chairman*

C. P. S. STUDY COMMITTEE

To the President and the House of Delegates:

The committee of fifteen, after devoting many doctor-hours to the project, made a report to the Interim Session, which has already been published.

Respectfully submitted,

WILBUR BAILEY, *Chairman*

C. P. S. FEE SCHEDULE COMMITTEE

To the President and the House of Delegates:

This committee has held no meetings and conducted no business during the year. Its report of December 1951 was not accepted. In November of 1952 the Council ordered that the work of this committee be integrated with the Medical Services Commission. This committee is, therefore, awaiting direction from the Medical Services Commission.

Respectfully submitted,

DEWITT K. BURNHAM, *Chairman*

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

San Diego County.

Francis E. West, San Diego, *Councilor.*

San Diego County Medical Society

The year 1952 was one in which many new activities were undertaken by members of the society. It was a year which saw the formation of a record-breaking number of committees, each of which was interested in solving the immediate problems by action!

Numerous projects were successfully completed as a result of the increased interest shown by members in affairs of the community. Foremost among these accomplishments was the work performed by committees which were established to meet with the central labor council, press and radio, and chamber of commerce.

The accomplishments of each committee have insured a better understanding of the problems facing the groups involved.

The society took cognizance of the rapid growth of all communities in the county and found the necessary steps to keep the emergency call system abreast of the tremendous influx of population occurring in this area. All physicians were reclassified as to specialty and as to their desire and ability to take emergency calls. The results of the classification survey have enabled the society-operated call system to maintain the standards which were established in 1933 and which have been met ever since. Here again was an example of the profession recognizing its duty to the public and the committee working fast to accomplish the objective.

The society library continues to improve its facilities and the service it offers to members. Physical improvements were made in an effort to give the library an attractive appearance and a professional atmosphere. A steady increase in utilization is the reward.

Outstanding speakers from all parts of the nation were guests at the monthly dinner meetings. The good attendance record attests to the success of the programs. A new plan for calling doctors during the evening has met the approval of all in attendance.

The medical society took great pride in its display at the county fair at Del Mar—the "Mechanical Quackery" exhibit of the A.M.A. An all-time high was reached in the number of persons who attended the fair. Many favorable comments and letters were received from business organizations and the public on the fine service the society rendered by displaying quack devices that had been used by charlatans to defraud the public.

Another "first" for San Diego was the joint dinner meeting of the Woman's Auxiliary and the medical society. The hilarious skit presented by the ladies played no small part in the success of the first joint meeting.

The Doctors' Service Bureau has continued to grow and improve its many services. Another society-operated project, the San Diego Blood Bank, is a successful community establishment.

The Building Committee, charged with the responsibility of formulating plans for a society building, has made progress. The year 1953 will see definite plans developed and openly discussed.

Our members were proud to host the maxillofacial surgeons for their annual convention in October in Coronado. The southern California chapter of the American College of Surgeons also convened in Coronado. Many of our members attended both conventions.

W. H. GEISTWEIT, JR., *Secretary*

SECOND DISTRICT

Imperial, Inyo, Mono, Orange, Riverside and San Bernardino Counties.

Omer W. Wheeler, Riverside, *Councilor.*

Imperial County Medical Society

Early in the past year an emergency medical care service on a 24-hour basis was established for the residents of Imperial County by the county medical society maintaining a roster at the hospital office with a physician assigned to this service each day. This was advertised in all the local newspapers and the cost for said publicity was taken care of by the public relations department of the California Medical Association.

The constitution of the medical society was amended to provide for a nominating committee to select an official ballot of candidates for the annual election of officers rather than the previous method of nomination of candidates at the time of the election without any previous forethought.

The society holds its regular meetings the second Tuesday of each month at 8 p.m. at the Pioneers Memorial Hospital. The scientific program is followed by a business meeting.

ERNEST BROCK, *Secretary*

Inyo-Mono County Medical Society

The Inyo-Mono County Medical Society has had very successful meetings the past year. We have had Dr. John W. Green, president of the C.M.A.; Dr. Omer W. Wheeler, councilor from Riverside; Dr. Arthur E. Varden, councilor from San Bernardino, and Ben Read from Los Angeles County speak at our meetings.

We have had various medical films shown, sent to us from pharmaceutical houses, and we enjoyed them very much.

Dr. Hill arranged our cancer program, and showed a film on the early diagnosis of cancer. Dr. Dowd gave a talk on "Early Detection of Cancer" which was enjoyed by the entire society and their guests.

We felt we were very instrumental in assisting the election of the President of the United States. We sent out more than 200 letters to our patients and the other doctors did the same. The result was a heavy landslide of Republican votes. The society paid for a half page ad in the local paper. The doctors all signed the ad and paid $114 for it and they were all glad to do it.

Dr. Green advised us to write to our senators and representatives. We did and had replies from them saying they would pay particular attention to the bills when they came up.

J. CARL CUMMINGS, *President*

Orange County Medical Association

The society's program of effective committee organization, coordination of projects and emphasis on internal relations, as well as public relations, has continued to be our basic objective in 1952.

The Program Committee has been most successful in obtaining outstanding medical lecturers and professors from schools of medicine to appear as guest speakers at the monthly society meetings. These meetings have continued to draw excellent attendance and the interest in the speakers and their subjects has shown a steady increase as a direct result of the excellent work of the committee.

Perhaps the most active committee was our Public Service Committee, which was established in 1950 for the purpose of hearing complaints from the public in an effort to establish better doctor-patient relations where misunderstanding existed. The committee reviewed and adjudicated fifteen cases.

The Public Relations Committee again ably carried out its assignment of publicizing medical society policy regarding the availability of medical care for persons unable to pay for it and also the policy of providing medical care 24 hours a day seven days a week.

The association's Civil Defense Committee continued to lead the way for other comparable groups throughout Orange County. Our geographical location on the fringe of the "critical target area" has caused this committee to be very active.

The Woman's Auxiliary continued active in many fields of aid to the profession and service to the public. Recruitment of student nurses, aid to nurses at the county hospital and allotment of scholarship funds to nurses for both undergraduate and postgraduate work—these were some of the Auxiliary's constructive activities. Through closer correlation of the Auxiliary and society's activities, even more material gains are anticipated during the coming months.

Mr. William Tobitt, executive secretary of our society for the past two and one-half years, tendered his resignation, effective January 1, 1952, to pursue his life-long desire of script writing for radio and television. Numerous applicants were interviewed for the vacated position, and Mr. Everett Bannister of Santa Ana was selected. Mr. Bannister's broad experience with public work will serve him well in his new position.

The medical society and the citizens of Orange County held their official opening ceremonies for the new 75-bed Hoag Memorial Hospital, located on the bluffs of Newport Harbor. The hospital, built entirely from private funds donated by the citizens of Orange County, plus a $500,000 grant from the Hoag Foundation, received its first patient on September 6, 1952.

Our membership has continued with a steady growth, keeping in step with the gradually increased general population. Our roster at the year's end encompassed 224 active members, plus 17 applicants due for processing early in 1953.

CHAD M. HARWOOD, *Secretary*

Riverside County Medical Association

The annual doctors' and wives' banquet of the Riverside County Medical Association will be held January 21, 1953, at the Victoria Club in Riverside. A golf tournament will precede the dinner dance.

The association meets the second Monday of each month at the Mission Inn in Riverside. A scientific program is presented after a short business session.

The R.C.M.A. Bulletin is published monthly and contains pertinent news and information for the medical profession.

RICHARD N. BOYLAN, *Secretary*

San Bernardino County Medical Society

Our membership has now settled down to a regular figure and we feel that our county is well supplied with physicians representing all phases of the practice of medicine and surgery.

The affairs of our society are in a healthy condition and our officers take an active interest in the management and conduct of our affairs.

Committees have been appointed to take care of many different special duties and without exception these committees are functioning and doing a good job.

We reported the condition of our blood bank last year. This blood bank has operated as a community enterprise and is sponsored by the San Bernardino County and Riverside County medical societies. The public has a high regard for the bank and it is already accepted as one of the essential parts of our community life.

CARL M. HADLEY, *Secretary-Treasurer*

THIRD AND FOURTH DISTRICTS

Los Angeles County.

H. Clifford Loos, Los Angeles, *Councilor*, Third District; J. Philip Sampson, Santa Monica, *Councilor*, Fourth District.

Los Angeles County Medical Association

Two important statistical changes figure prominently in progressive reforms made in Los Angeles County Medical Association administrative policies during the past year: First, that the membership has increased by nearly one-sixth since 1951 and, second, that the subsidiary branches in the outlying districts now compose 58 per cent of the active membership.

In hiring the management consultant firm of Booz, Allen and Hamilton to survey its operations, the association discovered that its growth into the largest organization of its kind in the country demanded numerous revisions in its former business and administrative policies. The recommended changes are now almost completed and should result in a savings of many thousands of dollars during the course of a fiscal year.

The large-scale public relations program approved by the Council last year has become a forceful and effective entity in association affairs during 1952: (1) A better integration of fee complaint and professional conduct matters to the end that both the physician and the public will be more quickly and satisfactorily served; (2) a newly-formed Medical Economics Committee to screen and study financial matters affecting the membership and, in particular, to set up uniform standards for collection agencies serving members of the association; (3) a concentrated radio schedule, under the supervision of the executive secretary, to bring the profession's good deeds before the public eye.

To remedy any real or fancied wrongs being dealt local general practitioners, an association-sponsored committee —representing hospitals, GP's, and specialists—has been set up to study the problem and has made heartening progress since its inception. As in the past, the association's Smog Committee and Civil Defense Committee continued to study methods to better serve the public.

The advisability of the association's embarking on a $700,000 building program still is in abeyance, though everything short of actual construction has already been completed. It is possible that the final decision will be left up to an individual vote of the entire membership.

PAUL D. FOSTER, *Secretary-Treasurer*

FIFTH DISTRICT

San Luis Obispo, Santa Barbara and Ventura Counties.

A. A. Morrison, Ventura, *Councilor.*

San Luis Obispo County Medical Society

The following information is a synopsis of the activities of our society for 1952:

The San Luis Obispo County Medical Society held ten meetings during the year 1952, two were social and eight were a combination of scientific and business meetings. Meetings were well attended and the scientific discussions by guest speakers were received with enthusiasm.

The San Luis Obispo County Medical Society has continued to be an active backer of the Tri-County Blood Bank.

The society began sponsoring a malpractice, health and accident insurance program for its members and it has been subscribed to heavily.

Ten applicants were elected to membership in the society during the year. Total active membership now is 57, and our society will have two delegates at the C.M.A. convention.

Dr. Jim Scow was elected president for the year 1953.

JOHN H. WOODBRIDGE, *Secretary-Treasurer*

Santa Barbara County Medical Society

At the close of 1952 our society members total 168; 148 active, 3 associate, 2 doing postgraduate work, 2 in military service, 5 sick, 2 life members, 5 retired, 2 transfers, 9 new members, and 8 applicants to be voted into the society at the January meeting. The year was spent with Dr. G. Horace Coshow as one of our most active and energetic presidents.

The activities of our group are mostly carried on by 20 different committees, the majority of them being active.

The Program Committee has functioned well, having had eminent speakers covering a fairly broad field of professional endeavors.

The Blood Bank Committee reports that the bank is solvent financially and that they have met all requests for the tri-counties (Ventura, Santa Barbara and San Luis Obispo) and the armed forces. Larger quarters are now necessary and plans are under way for a new building; construction will most likely be started within the next few months. The property has already been purchased.

The Diabetic Committee, in conjunction with the Public Health Department, conducted a very successful "Diabetic Detection" week, testing about 300 people, 23 per cent of whom required further study. They were, therefore, referred to their own physicians.

Activity of the Public Relations Committee was principally in publicity, realizing the urgency of keeping the public informed and protected.

Our Disaster Relief Committee has two mobile support units organized and awaiting supplies and the hospitals are ready in case of need for expansion. Further plans are being formulated for Santa Maria and a public health team is in the process of being formed.

All problems presented to the Medico-Legal Committee were relatively small in nature and a satisfactory disposition was made of them.

A two-day postgraduate seminar was held in October. There were two meetings open to the public, one in Santa Barbara and the other in Ventura, the same topics being covered at both gatherings. They were: Public Enemy No. 1, Heart Disease; Public Enemy No. 2, Cancer; Public Enemy No. 3, Socialized Medicine. Between the two towns more than 1,000 people were reached. All facilities of the two communities were used—radio, newspapers and the various organizations—in order to reach the public.

We have been able to work with the Santa Barbara Junior College in getting two important courses of study included in their curriculum beginning in the fall of 1953: (1) A two-year program for medical assistants; (2) a 12-month vocational nurses' course.

Our Liaison Auxiliary Committee reports that the Woman's Auxiliary has not only been active and enthusiastic but also has given tactful cooperation throughout the year.

Other committees functioning are: Entertainment, Alcoholism, Public Health, California Physicians' Service, Public Health League, and Military. We have just recently appointed a committee to investigate thoroughly the various plans used elsewhere for handling the emergency and night calls problem and make recommendations for our society. Also a representative was selected to be on the Council for Social Agencies.

Our library is an important and well organized unit and a hitherto unmentioned phase of our society's work, as far as the pre-convention reports are concerned. In January 1942, Mrs. Emma Woods, of Carpinteria, presented the medical society with a gift of money for the purpose of founding a medical library. A committee of trustees was appointed by the president to administer the library fund and to supervise construction of library space, to purchase suitable texts and current medical journals. The question of space for the new library was solved by the offer of the Cottage Hospital of several rooms on the ground floor of the hospital, rent free and with utilities and janitor service provided. The nurses' library is housed in the same space. The office of the society is contained in one of the rooms.

During the ten years since it was established, the library has endeavored to provide its patrons with the most useful periodicals and books. Borrowing privileges are extended to members of Santa Barbara County Medical Society, members of the California Medical Association living in the state but outside of Santa Barbara, physicians who are not members of the S.B.C.M.S. but reside in the county, doctors of philosophy, and members of the sciences.

The library hours are 9:00 a.m. to 4:00 p.m. and 6:00 p.m. to 9:00 p.m., Monday through Friday. Red Cross staff aides assist during the afternoons. During the 1952 period attendance was: Patrons 9,396, visitors 543. Circulation: Books 2,914, periodicals 1,869. Interlibrary loans 489, and new books 102.

The new year holds promise of being both challenging and busy with our new president, Walter C. Graham, and our new president-elect, L. E. Heiges, Jr., also our new secretary, Arthur E. Wentz, and our same treasurer, Francis B. Zener.

ARTHUR E. WENTZ, *Secretary*

Ventura County Medical Society

Regular monthly meetings of the Ventura County Medical Society were held the second Tuesday of each month at the Colonial House in Oxnard with the exception of the annual meeting in December, which was held at the Ojai Valley Inn.

Our Public Relations Committee, headed by Dr. C. A. Smolt, has continued its very effective work and we feel that significant progress has been accomplished. In September a dinner was given for representatives of the press and radio in accordance with efforts to maintain a cordial and cooperative relationship. A central agency for collecting, editing and release to the press of articles and items of interest has been established. Our public relations information brochure was revised and improved, and increased distribution accomplished.

St. John's Hospital in Oxnard completed its new building and moved in shortly before the end of the year. It is a beautifully designed and exceptionally well furnished and equipped addition to the hospital facilities of our county.

The addition to the Ventura County Hospital is still under construction, and should be ready for occupancy about April.

Dr. Lewis Alesen, president of C.M.A., honored us with a visit at our October meeting and gave one of his inspirational talks.

The following officers will serve for the year of 1953: President, James M. Hunter, Ventura; president-elect, James H. Nelson, Ojai; secretary, Franklin K. Helbling, Ventura; treasurer, Robert E. Williams, Camarillo.

F. K. HELBLING, *Secretary*

SIXTH DISTRICT

Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties.

Neil J. Dau, Fresno, *Councilor.*

Fresno County Medical Society

With the increasing scope of the activities of the Fresno County Medical Society, many projects are necessarily continuing ones, some of which have been concluded during the past year, and several new ones which will extend into 1953. However, some of our accomplishments in 1952 may be summarized as follows:

In cooperation with the Public Relations Department of the California Medical Association, public service announcements were run in all county newspapers twice during the year, and a series of health education programs were broadcast over three local radio stations. A brochure "Medical Care for All" was published for distribution to the public. Early in the spring, a joint dinner meeting with representatives of the press and radio was held.

Co-sponsored by the C.M.A., the third annual Postgraduate Institute was held in October.

The committee on professional relations has continued to serve as a judicial body in indicating to the profession and the public various standards of medical practice and procedures in the community regarding ethics, fees, etc. In number of cases considered, this year has been very comparable to the preceding years. For the most part, misunderstandings and disputes were settled amicably.

Beginning with the October issue, the Tulare County Medical Society was made a part of *The Bulletin* by inclusion of a section devoted to the activities of this society. At the same time, the publication was increased from 32 to 36 pages.

Monthly scientific programs have been good with attendance showing a slight increase over previous years. The first orientation program for new members and applicants for membership was presented at the December society meeting. Because of the interest shown in this first indoctrination course, it has been recommended that similar programs be presented from time to time. A brochure "The Door to Service in Medicine" was published for distribution to the membership. Membership in the society increased from 258 to 265 members of all classes. Five members entered military service during the year, making a total of eight members now on active duty. Twelve active members were lost when Madera County formed her own society.

Other projects included the organization of the staff and medical practices of the Valley Children's Hospital, launching the fast tempo x-ray survey, working out problems at the Fresno General Hospital relative to care of private emergency patients, Crippled Children's Service, polio care, psychiatric service and the planning of the new tuberculosis hospital.

Improved public relations has continued to be the primary consideration of the society, and every project, no matter how far removed from the field of public relations, has been designed to make a definite contribution to this end.

JOSEPH A. LOGAN, *Secretary-Treasurer*

Kern County Medical Society

Nineteen fifty-two was a very eventful year for the Kern County Medical Society. The doctors have worked through various means to demonstrate to the citizens of the county the vital role the doctors play in providing adequate health facilities for the residents of the county.

April 15 marked a very historical day for Kern County. This date climaxed a long period of planning and hard work by members of the society to provide a ready supply of whole blood. On this date the first blood was drawn at the Houchin Community Blood Bank. The physical plant was made possible through the generosity of Mr. Elmer Houchin, who contributed the funds for its construction. The California Blood Bank Commission loaned funds to the local bank which provided operating capital which will be repaid at the rate of fifty cents on each unit of blood drawn.

The earthquakes of July and August reduced the hospital facilities of Kern County to a dangerously low level. It behooved the members of the society to act at once setting into motion the necessary mechanics to not only rebuild the loss, but to build a new hospital. On September 8, Hill-Burton Act funds were made possible to this earthquake-ridden county in the amount of $1,072,923 to rebuild Mercy Hospital to 120 beds and to build a new non-profit 103-bed Greater Bakersfield Memorial Hospital. Without any mechanics set up and without the aid of a professional fund raiser, the doctors put their shoulders to the wheel and raised almost two million dollars by January 8, 1953, in order to hold the Hill-Burton funds and bring closer to realization the long felt need of more private hospital beds. This campaign will continue until a total of three million dollars is raised. During 1953, rehabilitation will begin on Mercy Hospital and construction will be started on the new hospital. The Hospital Construction Committee is composed of Drs. H. W. Lange, W. H. Moore, F. J. Gundry, L. B. May, J. T. Stanton, F. O. Wynia, Seymour Strongin,

W. H. Macdonald, J. E. Vaughan, J. J. Coker, K. S. McKee, S. W. Iseminger, Sophie L. Goldman Rudnick, J. M. Kirby, Jack M. Hayes, and C. I. Mead. The community is deeply grateful to these individuals who have so generously given of their time and talents to fill one of the greatest needs this county has been faced with.

The Woman's Auxiliary, under the able leadership of Mrs. Jack M. Hayes, president; Mrs. Hall Ramirez, president-elect; Mrs. Robert Day, vice-president, and Mrs. J. Howard Varney, secretary-treasurer, working with untiring efforts, sponsored a benefit program to provide funds which will be used in the construction of the new hospital.

For the third year, the society has participated in the Hall of Health, a health display at the Kern County Fair. By the distribution of pamphlets and discussions with people passing through the booth, the public was informed of the activities and services of the doctors of the community. Also, members of the medical society donated 120 hours of service to provide the Fair Association with an attending physician.

In cooperation with the American Cancer Society and the Cancer Commission of the California Medical Association, the Cancer Committee provided the doctors of the county with a one-day Cancer Symposium.

The society holds regular monthly meetings the third Tuesday of each month. At these meetings the doctors are given an opportunity to hear outstanding speakers, not only in the field of medicine, but on any issue which directly or indirectly affects the health and/or welfare of the community.

On December 1, the society employed Eldon E. Geisert as executive secretary. Mr. Geisert is 29 years old, married and has one child. He has been a resident of Bakersfield since 1942. He is a veteran of World War II, holds a degree in Business Administration from University of California at Los Angeles and a license as a public accountant. He comes well recommended as experienced in the field of public relations. Our thanks to Mr. Vance V. Venables, who has served us so well during the past years. We wish him well in his new endeavor as Administrator for the County of Kern.

WILLIAM WINTHROP HALL, *Secretary-Treasurer*

Kings County Medical Society

The annual meeting of the Kings County Medical Society was held November 20, 1952. At this time the officers were elected for the year of 1953.

The society meets the second Thursday of each month. A scientific program followed by a short business session is usually held. The place of meeting varies from month to month in the different cities of Kings County.

WILLARD S. BRIDWELL, *Secretary*

Madera County Medical Society

The Madera County Medical Society received its charter and held its first meeting in January of this year. At present the society has 20 members who have completed a very energetic and successful year under the presidency of Dr. Smith Quimby.

Aside from organizing our own medical society, a staff has been organized at the county hospital for the first time. Also, a committee was set up to act as medical advisors to the county board of supervisors.

A public relations program was sponsored, in cooperation with the C.M.A., consisting of paid advertising in the local papers which advised the public of the medical services available county-wide.

The first time the doctors, lawyers, and dentists have ever had a get-together in Madera was under the sponsorship of the medical society.

The officers chosen for the second year of our society were: K. W. Butler, president; Omar Need, vice-president, and Herbert Weinberger, secretary-treasurer.

JACK A. BICK, *Secretary*

Merced-Mariposa County Medical Society

The pre-convention report of the Merced County Medical Society, District 6, is submitted herewith.

During the year 1952 four new members were admitted to the county medical society—John East, Richard Irvine, John Medefind and Robert Schiffler.

Two other members were elected and then transferred to San Joaquin County. They were A. W. O'Donnell and William Wheaton.

The following officers were elected for 1953: E. M. Soderstrom, president; William Fountain, president-elect and vice-president; John East, secretary-treasurer; delegates to the C.M.A., Shelby Hicks and George Pimentel; alternates, Hugh Haas and Avery Sturm; board of governors for three years, Jerry Wolohan and Max Brannon.

During the year our county society cooperated with the C.M.A. public relations department in sponsoring "Your M.D." and "Get a Doctor," public service announcements, in all the papers of the county. We also are sponsoring the radio series over the local stations and we have approved the public service announcements of the Doctors' Public Service Committee, which will be run in the next month or so.

Regular meetings were held on the fourth Thursday of each month at the Hotel Tioga in Merced at 7:15 p.m. and visiting M.D.'s are always welcome.

HARRY R. MAYTUM, *Secretary-Treasurer*

San Joaquin County Medical Society

Dr. J. Earl Longley of Tracy served as president of the society in 1952. The expansion of the program of activities of the society has been greater than in any preceding year in its history.

The board of directors appointed Dr. John T. McNally to be chairman of a committee to secure an assistant to the secretary-treasurer. After interviewing and reviewing the qualifications of numerous applicants for the position, Boyd Thompson, son of a former Stockton physician, was chosen for the position in April. The choice was a happy one, as almost solely because of Mr. Thompson's hard work most of the programs carried on by the larger societies employing an executive secretary have been instituted. An office for the county medical society was opened in June and has just been moved to larger quarters in the American Trust Building.

Real progress has been made in the improvement of community press relationship. Members of our society met with representatives of the press in June at the first annual press-medical dinner. A code has been set up and given to our members to facilitate the prompt and accurate reporting of medical news.

A roster indicating the location, phone number and specialty of the members was published and circulated in August. Dr. James R. Powell is editor of the newly established monthly Bulletin. Its first issue appeared in September. It is devoted largely to local society news.

A group professional liability program has been adopted by the society which is optional to the members. Because of drastic premium increases and of policy limitations by the insurance carriers, most of our members are insuring in the new group plan as soon as their old policies lapse.

The establishment of a society office and an advertising program have combined to produce a great increase in the work of the Public Service Committee of which Dr. E. Gough is chairman. Some 140 complaints have been considered during the year and it is felt that their final disposition has created public good will.

After more than one year of study, Dr. Virgil Gianelli presented a new constitution and by-laws to the board of directors. It was approved by the board and the membership and is now in operation. Dr. Gianelli has also been active in a project to secure funds to be used in construction of a new wing at St. Joseph's Hospital. More than $50,000 has already been pledged by the hospital staff and public contributions are now being solicited. Dr. L. P. Armanino again directed the annual Postgraduate Study Club lecture program. Dr. E. C. Harrington reports greatly increased activity by the local Red Cross Blood Bank. Approximately 60,000 pints of blood were drawn in 1952 of which more than one-half went to the defense program. The society has continued its regular weekly radio program and other programs sponsored by the C.M.A. were added. Eight scientific and two programs of general professional interest were presented during the regular meeting. Dr. Oliver Riggle of Lodi, after an illness of two years, died on April 19, 1952.

F. A. MCGUIRE, *Secretary*

Tulare County Medical Society

The Tulare County Medical Society has just completed another very successful year under the leadership of President J. H. Brady of Visalia. This society is composed of 82 active members and three retired members, and there are six applicants awaiting the completion of their six-month residency. During the past year, Gerald Casebolt and Charles M. McClure remained in military service, and Donald G. Lindsay and G. Wayne Powell entered military service from this county.

One signal honor that this society received through one of its members was the awarding of a fifty-year pin to Dr. Austin Miller of Porterville, which award was made at the California Medical Association meeting in Los Angeles in April of 1952.

During the past year a Library Committee was formed to work with the group at the Tulare County Hospital to establish an active, up-to-date library for the resident staff and attending staff at the hospital.

Through the efforts of the Fresno County Medical Society and members of our own society, space has been obtained in the Fresno County Medical Bulletin for the Tulare County society's use. We are providing two pages of advertising and are obtaining two pages for news items in this very useful medical bulletin. This been accomplished through the efforts of J. H. Brady, president of our society, and Patricia Tudbury, editor of the Tulare County section.

During the early part of the year, we cooperated with the Public Relations Bureau of the California Medical Association and were one of the first counties to put in the ads in the newspapers locally, establishing emergency telephone numbers in each of the communities, and the ad "Your M.D."

We had a very successful postgraduate course on Sunday, May 18, 1952, at which time visiting professors from the University of California at Los Angeles presented the program under the co-direction of Dr. George Amromin of Exeter, and Dr. Victor Badertscher of Dinuba. This course was well attended and with a $5 tuition fee paid by the participants, was entirely self-supporting.

Our Program Committee was very active this year, headed by Dr. Vincent Dungan of Visalia, and several interesting programs were developed. During February and March. Drs. H. C. Hinshaw of Stanford University and Charles E. Smith of University of California presented papers at our meeting on bronchogenic carcinoma, pulmonary tuberculosis and coccidioides. These two meetings were made possible through the cooperation of this society and the Tulare County Chapter of the Tuberculosis Association. In May we were able to provide the speaker for the annual joint meeting with the Tulare County Bar Association, at which time we presented Dr. Ralph Gampell of San Mateo, who spoke on "Flight to Utopia," which is a very excellent talk on Dr. Gampell's experiences with the socialistic system in England and why he came to this country to get out from under such a program. We would recommend this talk to any of the societies which have not heard it, as he is a very interesting and forceful speaker.

We had an interesting ladies' night on November 20, at which Fred Frazer was the principal speaker.

On the other months of the year we had an annual visitation of the state officers of the California Medical Association, and Dr. Howard House of Los Angeles discussed ears, Dr. I. Y. Olch of U.S.C. discussed management of breast carcinoma, Dr. Longshore of the California State Health Department put on a program during the summer on equine encephalitis, and Dr. Robert Day of Bakersfield discussed dermatology, and Dr. Mischka Grossman discussed special procedures in diagnosis of congenital heart diseases. Dr. Mark Zeifert discussed neurology in private practice.

Officers elected at our regular December meeting on December 18, 1952, are Robert D. Karstaedt, president; Vincent M. Dungan, secretary-treasurer; J. J. McNearney, vice-president; Frank Kohn, member of the Board of Censors. Delegates to California Medical Association House of Delegates are James E. Feldmayer and Robert D. Karstaedt. Alternate delegates are C. H. Johnson and Ralph Miller.

ROBERT D. KARSTAEDT, *Secretary-Treasurer*

SEVENTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties.

Hartzell H. Ray, San Mateo, *Councilor.*

Monterey County Medical Society

The Monterey County Medical Society had a very successful year in 1952. The caliber of the scientific programs was exceptionally good. We cooperated 100 per cent with C.M.A.-sponsored radio programs and public relations advertisements.

We joined with Santa Cruz and San Benito counties in a combined meeting to foster better relationships and friendship with our neighboring medical brethren.

We sponsored a Boy Scout health lodge at the new Boy Scout camp and have raised one-third of its total cost of $6,000 during the past year.

Our public relation has been very good and we hope to keep it that way.

The new officers for 1953 are: President, H. M. Stufflebam; secretary, Horace F. Hussar; treasurer, Joseph J. Shebl; president-elect for 1954, Allen C. Mitchell; delegates, James H. McPharlin and Ernest Simard; alternates, Allen C. Mitchell and Howard C. Miles.

We feel sure the year 1953 will be equally successful.

FRANK P. CUSENZA, *Secretary*

San Benito County Medical Society

The first meeting of the year was held at the Holland Hotel on the evening of January 15, 1953, in Hollister. Dr. David G. Young, Jr., president of the local society, introduced to the society members and their wives Dr. Green, president-elect of C.M.A.; Dr. Hartzell Ray, regional councilor, and Glenn Gillette, public relations officer of C.M.A. Dr. Green presented a most enlightening talk on medical education endowment and the procurement program for prospective nurses.

Prior to the dinner meeting cocktails were served to the guest speakers and the doctors and their wives in the reception room of Dr. David G. Young, Jr.'s newly completed medical building.

San Mateo County Medical Society

The year 1952 has seen the San Mateo County Medical Society grow to a total of 334 members of all types. This society has taken a leading role in negotiations with labor unions and other organizations interested in designing satisfactory health and welfare programs, and considers this phase of its activity one of the most pressing issues for the coming year. Several programs during the year were devoted to this subject. Other programs dealt with scientific subjects and there was also a very successful barbecue attended by members and their wives.

Dr. Alf T. Haerem was elected president and Dr. Bradley C. Brownson president-elect for 1953. Dr. Jackson T. Flanders of Redwood City was made the new secretary-treasurer.

The growth in membership has made the society eligible for its sixth delegate and alternate delegate to the C.M.A., who were duly elected.

The society publicized its public relations program in newspaper advertising which met with popular acclaim.

BRADLEY C. BROWNSON, *Secretary*

Santa Clara County Medical Society

As 1952 draws to its inevitable conclusion, it is the duty, I believe, of your president to render in summary form an accounting of the highlights of the year. Fortunately no decisions of momentous importance were thrust upon us. However, following the pattern of the last several years, your society has pushed relentlessly for wider recognition and has assumed willingly the added responsibilities which this recognition demands.

In the field of local government cooperation we asked for and were accorded the privilege of acting as the screening body in selecting the Director of County Institutions. It was at our instigation that the unfair provision in the county charter which denied seats on county boards and commissions to physicians who serve voluntarily without pay on the staff of the County Hospital was successfully removed by the electorate.

In the field of voluntary health insurance we have expressed a willingness to experiment. Should it not conflict with the plans of the study committee on Prepaid Health Care of the California Medical Association we may institute on a county-wide basis the pilot program for a deductible-type insurance to be issued by California Physicians' Service. In addition, we have assisted the latter organization in setting up a complete processing office for C.P.S. claims at the county level.

Public relations was an important item this year. Most significant was our decision to broaden our relationship with the press by permitting the use of doctors' names in connection with feature articles detailing new discoveries or techniques or human interest stories. The work of our Public Service Committee in resolving doctor-patient misunderstandings deserves special mention here.

Most noteworthy, perhaps, was the action to really get going on a building program. By authorizing the purchase of real estate, this project has taken a tremendous spurt and it is hoped that with careful planning a long cherished hope will soon come true.

I wish to express my unbounded gratitude to all those officers, councilors and committee members who assisted me so faithfully and well in directing the affairs of the county medical society. It would be unfair to single out any individual or group since everyone who was asked to perform a task responded willingly and with enthusiasm.

We all owe a special vote of thanks to Mr. Joseph Donovan who possesses that rare gift-combination of cheerfulness, patience and efficiency. His aid and assistance reaches into almost every phase of medical society activity. The Auxiliary, also, should be mentioned for its willing cooperation whenever a request for assistance was made.

To Dr. George Waters and his incoming officers, my sincere best wishes for the ensuing year.

ALBERT R. CURRLIN, *President*

Santa Cruz County Medical Society

Dr. J. A. Ludden, Jr., of Watsonville served as our president during 1952 and a very successful year was recorded. As in the past the system of bi-monthly meetings was continued. Meetings are held at Deer Park Tavern, Aptos, which is centrally located for members coming from both ends of Santa Cruz County. The January meeting was devoted to the annual visit of C.M.A. officers who brought the members up to date on C.M.A. and legislative matters. The Society cooperated with the C.M.A. public relations department in sponsoring public service announcements in all newspapers of the county.

In March Dr. H. Clare Shepherdson of San Francisco presented a paper on Diabetes Mellitus. The May meeting was addressed by Dr. E. Overstreet of the University of California Medical School who talked on Infertility and also on Dysmenorrhea. Dr. Frederick Reichert of Stanford was with us in July and talked on the subject of Pain of Sympathetic Origin. In September the counties of Santa Cruz, Monterey and San Benito held a joint meeting and the speaker was Dr. Frank Tallman, State Director of Mental Hygiene, who presented a paper on Treatment of Mental Illness. The November meeting had as speaker Dr. Roy Cohn of Stanford who addressed the gathering on the subject of Abdominal Pain as an Entering Complaint. The annual business meeting was held at this time and Dr. P. E. Karleen of Soquel was elected president for 1953.

SAMUEL B. RANDALL, *Secretary*

EIGHTH DISTRICT

San Francisco County.
M. Laurence Montgomery, *Councilor.*

San Francisco Medical Society

Probably the most significant development of the year in San Francisco in 1952 was the impact on the members of this society, as well as the public, of what has become known as the "Weinerman Report" and the highly publicized demands of its sponsors, the San Francisco Labor Council.

Insisting that health coverage for union members and their families in San Francisco was inadequate, the report which was released to the local press by the Labor Council, called for the establishment of health centers, fee schedules, and numerous other projects. This suggestion of a possible change in the trend of the practice of medicine—one with widespread implications—called for immediate action by the board of directors. A special Union Labor Health Plan Study Committee was appointed to analyze and review existing labor and other health and welfare plans, as well as the demands and proposals of the Labor Council. Prompt cooperation and assistance came from the A.M.A. and the C.M.A. in the form of their representatives conferring with the Study Group. Other medical societies throughout the United States, in answer to inquiries regarding health plans in existence in their territories, also extended all possible cooperation. The membership of the society was advised, at two general meetings, of the various aspects of the problem, and all information gathered by the committee was presented.

In October, a questionnaire was sent to the membership which asked three pertinent questions: (1) What position should the San Francisco Medical Society take with regard to the present change in union health and welfare plans within the city of San Francisco? (The change referred to is a plan to establish a health center under a panel system, and to discard the right of free choice of physician.) (2) Should the medical society formulate a plan of its own to be set up and approved by the society under which services would be rendered to any and all prepaid medical plans which meet the approval of the society? (3) If such a plan is formulated, it will require the adoption of a fee schedule to apply to income brackets below a certain income and subject to periodic revision. It must further be under the direct control of the membership of the S.F.M.S. Would you approve of further effort to formulate a fee schedule to be presented to the members at a later date for their consideration?

Of 890 questionnaires returned, question No. 1 was disapproved in principle by 832 members; 776 said "yes" to question No. 2, and 779 approved question No. 3 regarding the formulation of a fee schedule.

The study group reported the results to the board of directors and recommended that: the society's Union Labor Committee contact union labor leaders and let them know the results of the questionnaire; all of the fallacies existing in the Weinerman report should be pointed out to the Labor Council; an attempt should be made to convince labor officials that the medical profession and labor leaders have the same basic objective, namely, to improve medical care in San Francisco, and have labor work together with the medical society in working out our approved or accepted principles; the union labor committee also to do everything possible to make existing plans function well.

The study group further recommended that new or existing committees be given the task of studying the proposed fee schedule as well as the proposed society-sponsored plan for approval of health plans, and that another special committee be appointed to work out a good positive public relations program; also in order that their work might be closely integrated, a coordinator should be appointed.

The board approved the report and followed through on the recommendations; the committees have been at work for several months, and it is felt that 1953 will be a most decisive year for the members of this society.

One hundred and twenty-nine new members were admitted to the society during 1952, and we suffered a grievous loss when death took 24 of our members.

An important project was completed when the society, after a long-time search, found a suitable piece of property at Turk and Masonic streets, on which, in time, a new building will be erected to house our administrative offices, an auditorium capable of seating 1,000 persons, and with adequate facilities to handle the growing activities of the society's blood bank.

Because of the increasing demands for the appearance of physician members on radio and television, the society's committee on those mediums drew up the following criteria to govern all public appearances by members. (1) The individual (physician) appearing should present himself with proper professional bearing; (2) he shall make no reference to himself; (3) he shall have a worthwhile educational message; (4) he shall prepare himself thoroughly in advance; (5) he shall forward his radio or television script prior to appearance; (6) he shall be limited to three appearances yearly except under conditions where other personnel are not available. In addition, the committee, with the approval of the board of directors, organized a panel of physician-members who are available for radio and television appearances, as well as public addresses, when necessary.

All local radio and television broadcasting companies, and major health and quasi-medical organizations were advised of the formation of the panel, and of the above criteria, so that as far as possible the scheduling of radio and TV appearances will be centralized through this society.

In the field of public service, we continued to help the community by means of our well-established emergency referral service, our Bureau of Medical Economics, our blood bank, and our Professional Relations Committee. In addition, this society presented two open panel discussions for the benefit of the community; one on the subject of arthritis, and the other on cancer. Both meetings were well attended, and similar sessions are planned for the future, in order that authentic medical education may be made available to as many people as possible.

The society's scientific sections continued to meet monthly, and in addition two banquet meetings were held during the year; one in honor of J. C. Geiger, retiring director of public health, and Karl Meyer, who was also lecturer of the evening, and the other featuring J. Garrott Allen, professor of surgery, University of Chicago, in an excellent summation of current concepts of ulcerative colitis.

The society's chest minifilm service is entering its fifth year. During its four years of operation a total of 49,527

minifilm chest examinations have been made, and one in 25 were reported as suggestive of tuberculosis.

From November 1, 1951, through October 31, 1952, a total of 112,522 net donors have contributed to the Irwin Memorial Blood Bank of the San Francisco Medical Society, an increase of 24,726 blood donations over the 1950-51 procurement. The bank continues to actively participate in the Armed Forces blood program, and is now cooperating in the newly organized national blood program which promotes blood donations for the Armed Forces, civilian blood needs and civil defense. The society's bank has distributed over 130,075 units of whole blood for the defense program through October 1952. In addition, transfusion therapy is provided upon request of local medical societies, to Shasta, Siskiyou and Mono counties in California and western Nevada. Blood is procured from these counties by means of the Southern Pacific blood donor car *The Life Line* which was officially dedicated and assigned to our bank in November of 1951. Blood donations are credited to the individual county blood reserve funds. Our bank, in turn, routinely stocks designated hospitals in each area with blood of all types from which other hospitals in the county draw. Donor replacements for units used are automatically withdrawn from the county's fund. This plan has proven very satisfactory.

At the beginning of 1952, the society's Committee on History and Obituaries undertook the preparation of the history of this society. An account of the early attempts to form a San Francisco Medical Society started in the February 1952 issue of the *Bulletin*, and has been appearing each month until the January 1953 issue, in which Section I, covering the period 1850-1868, was concluded. The next section dealing with the formation of the present society (which was 85 years old in February) will start in the March 1953 issue of the *Bulletin*, and will continue on until the present era is reached.

The Hearing Center has made great strides toward fulfilling its objectives. Incidentally, San Francisco is the only city to have a full-fledged Aural Rehabilitation Center under the guidance of its county medical society, serving all doctors and the entire community.

Space does not permit discussion of the various other activities of this society and its committees. As always, the society has striven to serve the community and its membership. Its objects remain as outlined in its constitution: "to promote and develop the science and art of medicine, to conserve and protect the public health, to promote the betterment of the medical profession . . ."

Much was accomplished under the leadership of Stacy R. Mettier in 1952. As we go forward into 1953 with our new president, Edmund J. Morrissey, we feel the problems ahead will not be easy to solve. Some are vital, and decisions will have to be made, as President Morrissey stated in his January message to the membership, "which may influence the trend of medicine, not only in our own locale, but even on a national scale." We keenly feel our responsibilities, and will do the best we can to find the right answers.

DONALD MCLEAN CAMPBELL, *Secretary-Treasurer*, 1952

NINTH DISTRICT

Alameda and Contra Costa Counties.

Donald D. Lum, Alameda, *Councilor.*

Alameda-Contra Costa Medical Association

At the close of 1952 there were 1,396 members of the Alameda-Contra Costa Medical Association. During the year the association's by-laws were amended to provide opportunity for eligible aliens to become members of the A.C.C.M.A.

Plans for a new A.C.C.M.A. blood bank and headquarters building have been approved by the Council, and construction is expected to be completed in mid-1953.

The Committee for Graduate Medical Education of the A.C.C.M.A. and the Institute for Metabolic Research at Highland-Alameda County Hospital are offering a postgraduate course in metabolic and endocrine diseases at the hospital from February 2 to February 7. Arrangements have been made by a committee headed by Dr. Laurance W. Kinsell, director of the Institute for Metabolic Research, and will include a faculty of 42 outstanding medical teachers.

The association lent to the California Medical Association the half-time services of its executive secretary, Mr. Rollen Waterson, to serve as executive secretary of the C.P.S. Study Committee.

GRANT ELLIS, *Secretary*

TENTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano and Sonoma Counties.

Warren L. Bostick, *Councilor.*

Humboldt County Medical Society

As in the past few years, 1952 saw the continued growth of the Humboldt County Medical Society by the addition of new members representing both general practice and various specialties.

Our monthly meetings, under the guidance of President Frank O'Neil, were well attended since many important business matters of interest to all were usually on the agenda. Our scientific programs consisted chiefly of case discussions, C.P.C. reports, and an occasional talk by a visitor or some member of the society. Our hospital staff meetings filled in to a great degree on the academic problems.

Nineteen fifty-two also saw the start of what everyone hopes will be a permanent C.M.A. program—that of a postgraduate lecture series for the northern counties. Under the able guidance of Dr. C. A. Broaddus, ten weekly lectures were given by various members of the staff of the Stanford Medical School. Each week the discussions were lively and lengthy, usually having to be brought to an end because of the late hour. Our society was well represented at all meetings, and we hope that they will be continued in 1953.

For the year '53 we start with the following officers: E. Kenneth Smith, president; Clarence Crane, Jr., vice-president; James S. Eley, treasurer; John W. Schonwald, recording secretary; Ted W. Loring, corresponding secretary. Nineteen fifty-three will provide us with a new St. Joseph's Hospital and a completely remodeled general hospital, thus providing for the community very much improved medical facilities.

TED W. LORING, *Corresponding Secretary*

Napa County Medical Society

The Napa County Medical Society held meetings each month in 1952 with the exception of August. We were privileged in having the following guest speakers who discussed topics in their respective fields: Dr. Francis Chamberlain, Dr. Harry Blackfield, Dr. John W. Green, Dr. Jack Benedikson, Mr. Tom Hadfield, Dr. Robert Sherman, Dr. William Porter Forcade and Dr. L. J. Regan.

Our March meeting was held, as usual, at the Napa State Hospital where the society was the guest of the institution.

In June of this year, it was Napa County's pleasure to be host to Solano, Marin and Sonoma counties at the annual four-county meeting. The dinner meeting was preceded by a "sizzling" golf tournament in the afternoon. Ninety-six doctors were present.

In September, Dr. Dale E. Barber, president of the society, was host to its members and guests, giving a barbecue dinner at his home. Dr. Warren Bostick, our new District Councilor, was introduced to the society by the C.M.A. president-elect, Dr. John W. Green. The society was also honored at this meeting by the presence of Mr. Ben Read, Mr. John Hunton, and Mr. Ed Clancy.

The November meeting was held at the veterans' home in Yountville with Colonel Holderman and Dr. Hohnstein hosts for the evening. Their hospitality is unparalleled and certainly most welcome. At this time the following officers were elected for 1953: President, Fred Heegler; vice-president, Harold James; secretary, Merle Godfrey. Delegates elected to the C.M.A. were Dale E. Barber and his alternate, Herbert Messinger, and Walter H. Brignoli and his alternate, Donald B. Marchus.

In an effort to bring medical men in closer relationship with other professions, a joint meeting was held with the Napa County Dental Society in April. Their California president, Dr. Jack Benedikson, was speaker for the evening, talking on the fluoridation of water. In December, a joint meeting was held with the Napa Bar Association, our speaker being Dr. L. J. Regan of Los Angeles whose subject was of mutual interest to both societies.

The Napa County Medical Society has supported 100 per cent the public relations program of the C.M.A. for 1952.

This year the society suffered the loss of our very able and respected secretary, Dr. Robert Starr Northrop. His death was a great loss not only to the society, but to the community as well.

The meetings of 1952 were most educational and exceedingly well attended.

DALE E. BARBER, *President and Secretary*

Solano County Medical Society

The activities of the Solano County Medical Society were under the able guidance of our president, Dr. Harry Lammel, and Dr. Melvin Schmutz, program chairman, who were responsible for many varied and interesting programs during the year, which included the following:

Dr. Benson Roe discussed "Surgical Diseases of the Esophagus." Mr. Hassard, attorney for C.M.A., spoke on "Corporation Infringement of the Professions." Dr. Seymour Farber presented a lecture on "Diseases of the Chest." Dr. Felix Pearl presented and illustrated a lecture on "Recent Advances in Cardiac Surgery."

In February the society was guest of the Travis Air Force Base hospital staff. An excellent program was presented by Lt. Col. J. T. Dresser who talked on "Review of Recent Advances in Orthopedics," and Col. A. H. Corliss and Lt. Dawson on "Medical Problems of An Aerial Debarkation Hospital."

The Solano County Medical Society was proud to have one of its members, Dr. John W. Green, elected as president-elect of the California Medical Association. Dr. Green has been active in local, state and national medical affairs for many years and we pledge him our wholehearted support for 1953.

The society took great strides this year in setting up a more efficient public relations program and with the able assistance of Ed Clancy and Glenn Gillette we are now bringing the county medical society before the public.

The newly elected officers for 1953 were Dr. Milton B. Smith, president; Dr. Carl V. Reichman, vice-president; Dr. Herbert L. Joseph, secretary-treasurer.

WM. R. HOOPS, *Retiring Secretary-Treasurer*

Sonoma County Medical Society

Nineteen fifty-two saw the Sonoma County Medical Society carrying forward the progressive program formulated during the past three years. The leadership of Dr. Leonard W. Hines, president, inspired the society to a highly successful effort.

The activities of the society were funneled through the central office in charge of F. L. Manker, a local attorney, the society's executive secretary and legal adviser.

A new constitution and by-laws was published in 1952, and a copy provided to each member of the society.

The members have continued to benefit by the group contracts with the American Mutual Liability Insurance Company and the National Casualty Company. The collection contract with the Redwood Empire Adjustment Bureau has continued to prove advantageous to all.

This society was especially active in public relations this year: Emergency listings were placed in the telephone directory; radio programs were presented; a press code of cooperation was published; several health forums were held as a function of the Speakers' Bureau and, in liaison with citizens of the community, the society helped to procure a new wing for the county hospital.

Seventeen new members were added in 1952, bringing the total active membership to 128 at the end of the year.

Intrasociety relations were improved by the continued and expanded publication of our monthly *Bulletin*, and by excellent scientific programs. Speakers included Drs. Joseph Catton, Loren Chandler, Emile Holman, Lowell Rantz, Harold Faber, Robert Newell, Karl Schaupp and Robert Westphal. A two-day North Coast Counties Institute, sponsored by the California Medical Association Committee on Postgraduate Activities was held in February. Joint meetings were held with the Woman's Auxiliary, including our annual barbecue in August at the home of Dr. and Mrs. William Makaroff. In October a joint meeting was held with the dentists, attorneys, pharmacists and veterinarians of the county, which was addressed by Dr. John Cline on the subject of Medicine in Politics.

In November, the annual visit of the officers of the California Medical Association, including Dr. John Green, Dr. Warren Bostick, Mr. John Hunton and Mr. Glenn Gillette, was a memorable one.

FRANK E. LONES, *Secretary-Treasurer*

ELEVENTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba Counties.

Wayne E. Pollock, Sacramento, *Councilor.*

Butte-Glenn County Medical Society

The Butte-Glenn Medical Society has had a profitable year largely due to the hard work of its president, Dr. Meredith Guernsey. Active committees have functioned throughout the year, especially the Public Service Committee, the Public Health and Public Relations. The Public Service Committee has forestalled at least four nuisance malpractice suits and is now organized to effectively handle future demands. The Public Relations Committee with the aid of the C.M.A. Public Relations Department has advertised the society's effective call systems and the public service activities. The Insurance Committee has established a working malpractice prevention program with American Mutual Liability Company. An active liaison committee has been established between the Butte County Hospital staff and the Board of Supervisors of Butte County. Dr. Hollis Carey was elected to be a Councilor-at-Large for the C.M.A. and is working hard and effectively for the medical interests.

There has been a large influx of new doctors to our counties and the society now numbers 55 active, five inactive and 12 prospective members. The society deeply feels the loss of Dr. John White who died in November 1952.

Dr. Donald Casey was elected president for 1953, Dr. Thomas Elmendorf, vice-president, and Dr. J. O. Chiapella again assumed responsibility as secretary-treasurer, a job he previously held for thirty years.

W. C. CHIAPELLA, *Secretary*

Placer-Nevada-Sierra County Medical Society

The Placer-Nevada-Sierra Medical Society held regular monthly meetings on the second Wednesday of each month except for June, July and August 1952. One meeting (May) consisted of a medical cancer symposium sponsored by the California Medical Association Cancer Commission and the California division of American Cancer Society.

The December meeting was a dinner meeting and Christmas party held in conjunction with the election of officers.

Officers elected for 1953 are as follows: President, Carl Jackson; vice-president, John R. Topic; secretary-treasurer, T. J. Rossitto; delegates to C.M.A.: Wm. Miller and Harry March; alternate delegates to C.M.A., Saul Ruby and Max Dunievitz.

Our medical society has been cooperating with the C.M.A. public relations department in sponsoring the public service announcement in all newspapers of the Placer, Nevada and Sierra counties.

T. J. ROSSITTO, *Secretary-Treasurer*

Sacramento Society for Medical Improvement

Organized in 1868, our society is the oldest medical society in the state of California and has enjoyed steady growth since its inception. The society now has 274 members. Society meetings are held on the third Tuesday of every month. An annual banquet is held on March 17, St. Patrick's Day, the anniversary of the foundation of the society. The December meeting is an annual business meeting, at which time the board of directors, C.M.A. delegates and the secretary-treasurer are elected. The president and vice-president are then elected from among members of the board at the January board meeting.

In 1950, the society hired a full-time executive secretary and launched a broad and extensive public relations program. As part of the program it has publicly announced an unqualified guarantee to every resident of the community of good medical care, 24 hours a day, regardless of ability to pay.

In order to fulfill the guarantee, the society maintains a central office which renders assistance in problems pertaining to medical care; maintains a 24-hour medical telephone exchange; social service handles referrals of part-pay or those unable to pay cases requiring medical services; referral service provides names of doctors and information regarding their education, training and field of practice; information service answers questions regarding medical care facilities and services; operates Sacramento Blood Bank; and Professional Conduct and Ethics Committee hears and attempts to adjudicate differences and disputes between a patient and his physician.

FRANK G. SCHIRO, *Secretary*

Shasta County Medical Society

The Shasta County Medical Society now has 27 active members, there having been two new admissions. Several scientific and social meetings were held, including a meeting addressed by Mr. Howard Hassard at which the Shasta County Bar Association and Dental Society were our guests.

Arrangements were made by the society with the Irwin Memorial Blood Bank so that through the use of the Southern Pacific *Life Line* blood donor car, the county's blood banking needs are being supplied. This has proven to be a most helpful service to the community, pending the construction of the Shasta Cascade Regional Blood Bank in Redding. Plans are progressing rapidly for this permanent community blood bank under the auspices of the Shasta and Siskiyou County Medical Societies.

The society has cooperated with the C.M.A. public relations department in establishing emergency referral numbers and sponsoring the "Your M.D." public service announcements. A series of weekly radio programs using A.M.A. transcriptions has also been instituted.

Plans are under way to establish in the coming year a loan fund for needy medical students from Shasta County. A yearly per capita donation by the society to the National Medical Education Foundation has been approved.

Officers for 1953 are Louis Nash, president; H. Harper Thorpe, vice-president, and Henry R. Eagle, secretary-treasurer.

Regular meetings of the society are held on the first Monday of each month.

HENRY R. EAGLE, *Secretary-Treasurer*

Siskiyou County Medical Society

Calendar year 1952 Siskiyou County Medical Society report follows:

We are particularly proud of the steps that our society has taken this year. We have cooperated with the A.M.A. and C.M.A. public relations programs in sponsoring the movie short "Your Doctor" in all local theaters, in displaying the plaque "To All My Patients," in our offices to encourage the discussion of fees, etc., in having our Public Relations chairman attend the fifth annual Public Relations Conference in Denver in November. We have cooperated with the C.M.A. public relations program by promoting A.M.A.-produced radio programs in both county stations, publicity in our local newspapers of our Public Service Committee and our emergency call system and the meaning behind "M.D."

On our own initiative we have done the following:

1. Created an information sheet, explaining all the anticipated charges of hospital, anesthesiologist, surgeon, assistant, etc., which is presented to all patients before or on entering our hospitals.

2. Promoted a successful campaign to procure blood with the aid of the Irwin Memorial Blood Bank group and the Southern Pacific *Life Line* car, and now have available blood stored in each end of the county.

3. Established a Public Service Committee.

4. Adopted a press and radio code.

5. Helped "delay" the increasing socialistic trend in the U.S.A.

6. Established a speakers' bureau wherein each society member has prepared a topic relating to our profession. A brochure of the speakers and their subjects has been distributed to civic organizations and interested groups. We are all on call as speakers.

For a small society of 16 members, we feel we have contributed a great deal, at grass roots level. Under No. 5 of our efforts, we feel the use of the word "delayed" instead of "defeated" advisable. As a motto perhaps, we should revive the old phrase, "We have not yet begun to fight."

E. V. ANDERSON, *Secretary*

Tehama County Medical Society

We feel that Tehama County has been forward-looking and progressive in its anticipation of further growth. The new district hospital in Corning and the new addition to the Sisters' Hospital in Red Bluff is adequate to care for the present and any foreseeable increase in population.

The Corning Memorial Hospital opened for admission of patients in January 1952 and there immediately arose a community controversy on the admission of an osteopath to the staff. The board of directors vetoed an osteopath on the staff, so at election time this fall an osteopath ran for a directorship. The public defeated him by a two-to-one vote.

The Tehama County Medical Society has been active in the C.M.A. grass-roots program, having publicized emergency telephone numbers in all newspapers of the county as well as a "Your M.D." copy. Likewise the society is sponsoring medical radio programs for a six-month period.

O. T. WOOD, *Secretary*

Yolo County Medical Society

The Yolo County Medical Society held regular monthly meetings during the year except in July and August. At each meeting a paper was presented and a discussion was held by outstanding medical and surgical specialists on a variety of subjects related to the practice of medicine.

The society was active in support of the local civilian disaster committee, both by participation and advice on medical problems.

In addition to individual contributions, the society voted an assessment against its treasury to be transferred to the American Medical Education Foundation.

A committee on publicity and one on heart, advisory to the county chapter of the California Heart Association, were formed during the year.

Dr. Herbert Bauer succeeded Dr. John Rafferty as public health officer for Yolo County.

New members admitted during the year were Dr. Bernard Kordan, Dr. Robert G. Adler, Dr. William S. Freeman, Jr., Dr. James Henry Kimbell, and Dr. Herbert Bauer.

RICHARD D. CUNDIFF, *Secretary*

Yuba-Sutter-Colusa County Medical Society

Ten meetings were held during the year.

Deaths: John A. Duncan, Peter J. Cress, Ira Higgins, and F. W. Didier.

Four malpractice cases were considered.

The guest speaker at the January meeting was Dr. John M. Baker of Sacramento, who presented a paper on thoracic injuries.

Mr. Glenn W. Gillette, associate director of public relations for C.M.A., discussed local newspaper publicity regarding emergency medical service sponsored and paid for by C.M.A. through the local society.

Guest speaker at the February meeting was Dr. Edward A. Macklin of the Langley Porter Clinic, who gave a very fine paper on the use of Antabuse® in problem drinkers.

Guest speaker at the April meeting was Dr. John M. Kenney, who spoke on the subject of "American Cancer Society."

A paper was read by Dr. Neal M. Loomis on medical ethics.

A special meeting was held in July, its purpose to discuss malpractice suits.

The annual banquet was held September 9, 1952, for the Yuba-Sutter-Colusa County Medical Society and the Auxiliary. Dr. John W. Green, president-elect of C.M.A., was principal speaker. Other speakers were Mr. Ed Clancy, director of public relations, C.M.A.; Mr. Glenn Gillette, associate director of public relations, C.M.A., and Mr. Ben Read of the Public Health League.

A business meeting was held in October.

A special meeting was held October 28, 1952, for the further discussion of malpractice suits.

At the November meeting the guest speaker was Mr. Edward Midland, exchange professor from England, who spoke on the British system of socialized medicine.

At the December meeting Dr. Frances P. Wisner as senior delegate gave a report of the recent meeting of the House of Delegates of the California Medical Association.

The following officers were elected for 1953: president, William J. Vasquez; vice-president, William R. Taylor; secretary-treasurer, Robert I. Hodgin; delegates, Frances P. Wisner and Stanley R. Parkinson; alternates, Charles B. Kimmel and Joseph J. Salopek.

Seven doctors were elected to membership during the year, also several physicians have moved from here to other locations.

LEON M. SWIFT, *Secretary*